



U. S.
NAVY

Medicine



September 1971

Vice Admiral G. M. Davis MC USN
Surgeon General

Rear Admiral J. W. Albrightain MC USN
Deputy Surgeon General

Captain M. T. Lynch MC USN, Editor

Mrs. Virginia M. Novinski, Assistant Editor

Mr. Ray Stevens, Art Director

Contributing Editors

Legal . . . Captain R. E. Blair JAGC USN

Nurse Corps . . . Captain A. M. Byrnes NC USN

Dental Corps . . . Captain A. K. Kaires DC USN

Preventive Medicine . . . Captain C. H. Miller MC USN

Occupational Medicine . . . CDR G. M. Lawton MC USN

Aerospace Medicine . . . Captain H. S. Trostle MC USN

Radiation Medicine . . . Captain B. K. Hastings MC USNR

Medical Service Corps . . . CDR J. M. Beckwith MSC USN

Submarine Medicine . . . Captain B. K. Hastings MC USNR

Research Medicine . . . Captain B. F. Gundelfinger MC USN

Amphibious & Field Medicine . . . Captain J. H. Stover, Jr. MC USN

Medical Corps and Gastroenterology . . . CDR D. O. Castell MC USN

POLICY

U.S. Navy Medicine is basically an official Medical Department publication inviting the attention of officers of the Medical Department of the Regular Navy and Naval Reserve to timely up-to-date items of official and professional interest relative to medicine, dentistry and allied sciences. The items used are neither intended to be, nor are they, susceptible to use by any officer as a substitute for any item or article, in its original form. The opinions and conclusions expressed in the articles or items included herein are those of the respective authors and do not necessarily represent the views of the Department of the Navy, the Bureau of Medicine and Surgery or any other governmental department or agency thereof.

DISTRIBUTION

U.S. Navy Medicine is distributed to active duty Medical Department officers via the Standard Navy Distribution List (SNDL) vice personal addresses. Any increase or decrease in the number of allotted copies should be requested via the local Commanding Officer through U.S. Naval Publications and Forms Center, Code 306, 5801 Tabor Avenue, Philadelphia, Pa. 19120. Other addressees may forward changes of address in the same manner, giving full name, rank, corps, old and new address, and zip code. The mailing label taken from the most recent issue should be forwarded if possible. See inside back cover for **CORRESPONDENCE AND CONTRIBUTIONS**.

The issuance of this publication approved in accordance with NAVEXOS P-35.

NAVMED P-5088

C O N T E N T S

FROM THE CHIEF 2

FEATURE ARTICLES

Doctors Answer the Call	4
Disaster Aid	16
Groundbreaking	30
"The Hawk" and Drug Awareness	41

PROFESSIONAL PAPERS

Entrapment of Deep Branch of Radial Nerve by Fibrous Attachment of Extensor Carpi Radialis Brevis: Case Report with Operative Decompression and Cure.	10
Approach to the War Injured by an Orthopedic Team.	12
The Hematologists' Corner — Cancer Chemotherapy.	22
Dental Emergencies in Children.	26

COMING AND GOING 40

LETTERS TO THE EDITOR 44

NOTES AND ANNOUNCEMENTS

Premium-Paid Mortgage Insurance for the Home- Buying Service Family	46
CHAMPUS	29, 48
MO Staff Assignments	49
Tropical Medicine Course	49
Postgraduate Short Courses for Medical Depart- ment Officers Sponsored by the Department of the Army During Fiscal Year 1972.	50
Seminars on Leprosy	52
Proparacaine for Tonometry	52
Continuation Pay.	52
Rhabdomyolysis	52
Intermittent Compression Unit Arm Board	53
Official Instructions and Directives.	56
Awards and Honors	61
American Board Certifications.	62
Animal Care Facility Accredited	64
Upcoming Meetings	64
In Memoriam	64

Credits: All pictures are Official U.S. Navy Photographs unless otherwise indicated.

Front cover photo was taken as colors were presented at Groundbreaking Ceremonies for the new Naval Hospital, Camp Pendleton, Calif. We are grateful for excellent pictures of that event provided by photographer HM1 Villaroman, Jr., USN, by courtesy of THE PULSE BEAT, Naval Hospital, Camp Pendleton, Calif. See Feature Article on Groundbreaking, page 30.

Page 2. VADM George M. Davis, MC, USN, Surgeon General, and Mrs. Davis, the gracious First Lady of our Medical Department (left), enjoyed an evening social with the staff officers and wives during a visit to Naval Hospital Camp Pendleton, Calif. Photo by HM1 M.R. Villaroman, Jr., USN.

Back cover photo reveals CDR Mary Dalmaso, NC, USN (right foreground) acquainting theology students with the basic approach to patient care at the Naval Hospital, NNMC, Bethesda, Md. In a cooperative program between NNMC and Washington-area theological seminaries, the five students attended an 11-week summer class in Clinical Pastoral Education.—PAO, NNMC, Bethesda, Md.

Graphic Arts Support rendered by Mrs. J. L. Bottazzi and Mrs. S. B. Hannan, Code 4542, BUMED, is gratefully acknowledged.



from the Chief

With the close of the official summer season and resumption of academic schedules, we take notice of the new additions to our ranks. It is my pleasure to welcome aboard new members of the Navy Medical Department, and to congratulate those selected for assignment to new areas of training or responsibility. You have emerged, highly qualified, from competitive academic life and troubled institutions to serve our Nation and all those who may benefit from your professional skill.

The initial ordeal of relocation, orientation and initiation has passed. As we settle down to the business at hand, with all of the labor, promise and frustration that may attend it, some comments of others who have traveled the same road come to mind.

The standards of medical care cannot be predetermined or imposed upon us — they rest inevitably with the individual practitioner. The uninformed and uninspired are neither redeemed nor condemned by their surroundings. Those who embrace intellectual challenge with enthusiasm and are determined to grow in professional stature will invariably find, or create, a constructive channel for their energies. For them, an experience will prove rewarding and worthwhile.

As our commitments abroad diminish, the opportunity to concentrate efforts on improving the delivery of health care services has been realized. Innovations in training, prototype systems exploring newer concepts of organization, and programs for improving skills and efficiency in patient care are now in progress. Many of you are pioneers, being among the first to participate in these ventures. There is a refreshing departure from stereotyped medical practices which most of us welcome. For the stimulating opportunities provided by this climate, we must be willing to assume the cost — hard work, patience, perspective and objectivity. It is not an opportune time for the faint-hearted.

There is no guarantee that all who seek assistance will obtain instant satisfaction within their respective commands. But it is certain that effective guidance and counsel will not become available to those who make no reasonable effort to obtain them. In a large organization that is widely dispersed and physically fragmented personal needs and desires are not always readily discerned. Major concerns are primarily mission-oriented. Mutual respect and active communication form a sound basis for professional satisfaction and productivity. Each of us is obliged to encourage and sustain this interchange. There can be no effective communication without operable transmitters and receivers.

In our zeal to pursue a bent for scientific investigation, managerial improvements and other goals, we must not overlook the prime object of concern, which is the patient. There is little to commend an act that causes discomfort, inconvenience, and anxiety, especially for a patient who is unenlightened concerning the purpose or objective of the action. We would all readily agree that resentment and fear are normal human reactions to the unknown, or threatening situations. Yet it is surprising how insensitive to those reactions we sometimes appear, to the detriment of patient satisfaction and therapeutic results.

United by the common challenge of high quality patient care, each of us can make a unique contribution. Our collective resources are enriched by the diversity of backgrounds and disciplines represented. Whether our close association be brief, extended, or lifelong, may it prove fruitful and memorable.



DOCTORS ANSWER THE CALL

*By CDR J.I. Myers, MSC, USN, Administrative Officer, CINCLANTFLT
Surgeon Headquarters of the Commander-in-Chief Norfolk, Virginia
23511. (Photographs by courtesy of PAO CINCLANTFLT.)*



RADM H. G. Stoecklein, MC, USN, Course Director, welcomes indoctrinees.

On 23 July, 155 newly commissioned reserve medical and dental officers completed an intensive three-week indoctrination program in military training at the Armed Forces Staff College in Norfolk, Va. The doctors and their families reported aboard on 6 July and came from as far north as Maine, as far south as Florida, and as far west as Utah.

While most of the medical officers came following their internship, there were a considerable number who had completed residency training in the various specialties. Six of the doctors assigned to the aircraft carriers had completed surgical residencies. It was the first taste of active duty navy life for many officers who received their commissions as inactive reservists.

During the three-week course conducted by the staff of the Commander-in-Chief U.S. Atlantic Fleet, the newly commissioned physicians and dentists entered the ranks of naval medical and dental officers. The curriculum included many of the subjects normally covered in the 90-day Officer Candidate Course at Newport, R.I. However, subject matter relating specifically to medical and dental officers was emphasized.



Amphibious Landing Capability Demonstration at the NAVPHIBASE.



Indoctrinees examine a tank at close range.

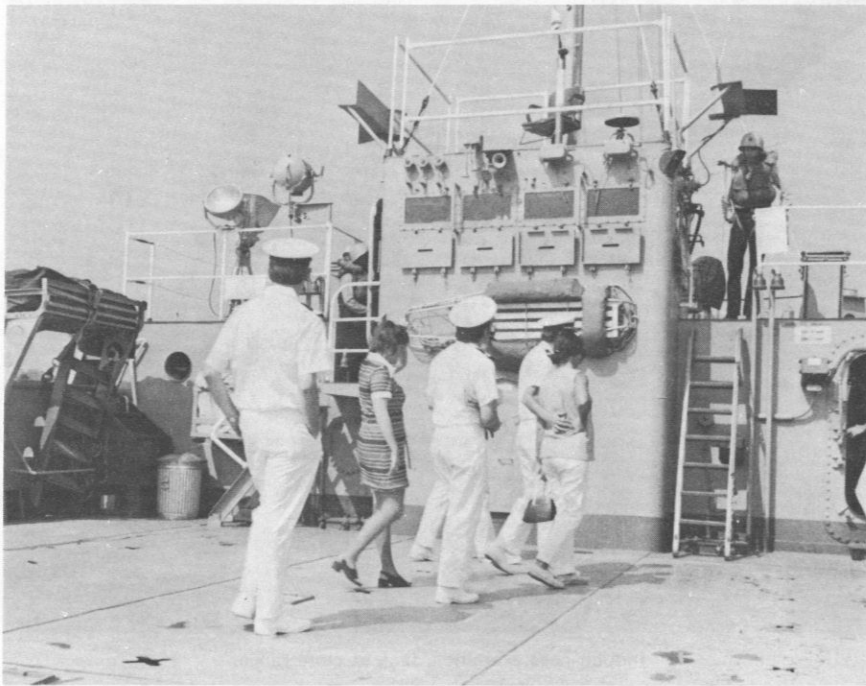
The course was unique in many ways: it was the first time the program was held in Norfolk; it was the first time the medical officers and dental officers were indoctrinated together; it was the first time the shore-based medical and dental officers were indoctrinated with the Fleet medical and dental officers; it was the first time the wives were included in the formal lectures and field trips.

The course officially opened with the "Welcome Aboard" address by RADM H.G. Stoecklein, MC, USN, Atlantic Fleet Surgeon, and Course Director. Welcoming remarks were also made by MAJ GEN J. F. Kirkendall, USAF, Commandant, Armed Forces Staff College; RADM J.L. Yon, MC, USN, Commanding Officer, Naval Hospital, Portsmouth, and; RADM V. L. Anderson, DC, USN, Fleet Dental Officer.

The doctors received indoctrination in such areas as History and Organization of the Navy; Naval Customs and Traditions; Military Duties of Naval Officers; Naval Terminology; Military Courtesy, Honors and Ceremonies; Leadership; Medical Jurisprudence; Personal Affairs; Hospital Procedures and Policies pertinent to Navy Doctors; and Military Psychiatry. A Bureau of Medicine and Surgery Seminar was conducted by BUMED personnel to advise the medical officers of the many and diversified programs offered by the Navy Medical Corps. A similar program was conducted for the dental officers.



Tank gun is viewed by indoctrinees.



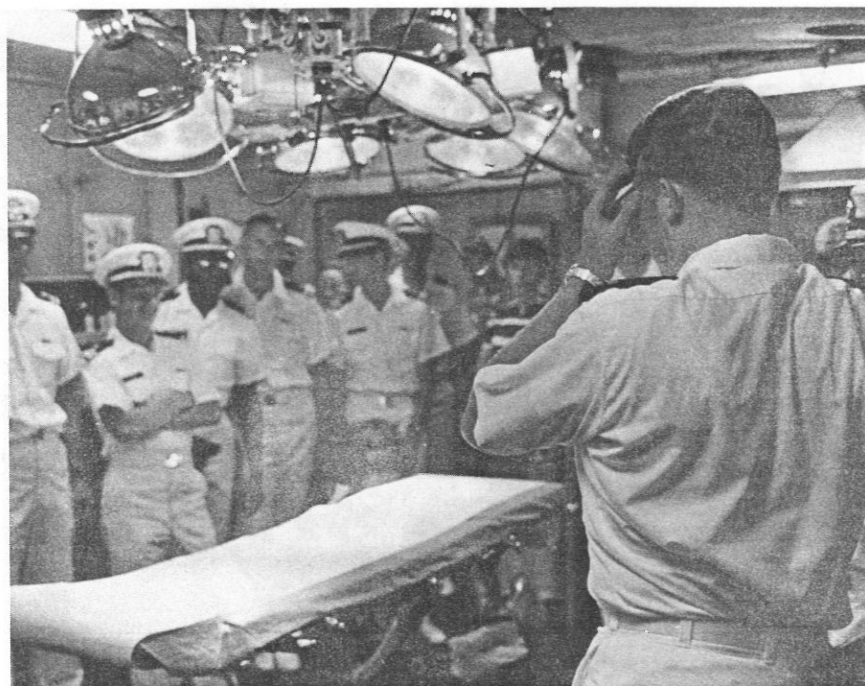
Visiting USS L. Y. Spear (AS-36).



Indoctrinee queries a Seal Team member.



Visiting USS Guadalcanal (LPH-7).



OR in USS Guadalcanal visited.



GUADALCANAL berthing spaces.



Indoctrinees on bridge of USS Guadalcanal.



VADM G.E. Miller, USN, received a standing ovation following his Second Fleet briefing.

The medical officers under orders to the Operational Forces were given additional lectures on Preventive Medicine; Nuclear, Biological and Chemical Warfare; Military Problems of Drug Abuse; and the Soviet Threat. In addition, they were briefed and taken on field trips by Force Medical Officer escort groups to view their respective type ships.

The doctors, accompanied by their wives, attended an Amphibious Capability Demonstration at the Naval Amphibious Base, Little Creek, and were greeted by VADM E.C. Bell, USN, Commander, Amphibious Forces, U.S. Atlantic Fleet. They also toured the USS L.Y. Spear (AS-36), a new submarine tender; the USS Guadalcanal (LPH-7); and the Naval Hospital, Portsmouth. The wives were also invited to many of the formal lectures. One of these was given by the CINCLANTFLT Briefing Team, preceeded by ADM C. K. Duncan, USN, Commander-in-Chief, Atlantic Fleet, who welcomed the officers and their families to the Fleet. RADM J.L. Abbot, USN, Inspector General, Atlantic Fleet, produced his special show which he has titled "Once Around the Med."


The highlight of the course was VADM G. E. Miller's Second Fleet briefing. The officers were well schooled on the Russian status and the ever increasing power of the Soviet Navy. Most important, a dramatic portrayal of Russia's great naval leader, Sergai Gorshkov, was given by VADM Miller. The indoctrinees expressed

their appreciation by rendering a standing ovation.

A personnel inspection was held on 16 July by RADM H. G. Stoecklein, MC, USN, and CAPT J. F. Link, DC, USN. Both complimented Troop Commanders G. W. Millard, MSC, USN, and R. G. Shaffer, DC, USN, on the outstanding appearance of their personnel.

Many social events were held throughout the course. The first of these was a tea given in honor of the indoctrinees' ladies by the Navy Medical and Dental Officers' Wives' Clubs, following the "Welcome Aboard" address. On the evening of 8 July, a cocktail party and buffet in honor of the attendees took place at the Commissioned Officers' Mess, Naval Station, Norfolk; over 300 were present. The Dental Wives' Club held a coffee for the ladies of the dental indoctrinees. On the evening of 22 July, a cocktail party with buffet was held at the SACLANT Mess to welcome the medical officers and their wives who were joining the Atlantic Fleet family.

After receiving their graduation certificates and felicitations for the traditional "Smooth Sailing, Fair Winds and Following Seas," the naval medical and dental officers departed for ship and shore billets as widely dispersed as Iceland, Morocco, and Scotland.

The officers and their wives had gained a better understanding of our world-renowned Navy, and the responsibilities they must shoulder to keep it that way. 

ENTRAPMENT OF DEEP BRANCH OF RADIAL NERVE BY FIBROUS ATTACHMENT OF EXTENSOR CARPI RADIALIS BREVIS: CASE REPORT WITH OPERATIVE DECOMPRESSION AND CURE*

By CAPT Frederick E. Jackson, MC, USN;** LCDR Paul M. Fleming, MC, USNR;*** LCDR Robert C. Cook, DC, USN;+ LT J. Jeffery Katzenmeyer, MSC, USN;++ and LTJG Sandra J. Peavey, MSC, USNR.+++

In the military practice of neurosurgery there is ample opportunity for observation of peripheral nerve palsies following missile wounds and traumatic fractures. However, an occasional *compressive* neurorrhaphy of a specific branch of a peripheral nerve presents such characteristic signs and symptoms and is a condition usually so readily improved with surgery, that a case report of a specific compressive neurorrhaphy involving the deep branch of the radial nerve in the forearm, is hereby described.

Report of Case

A 34-year-old staff sergeant, USMC, had noticed paralysis of the finger extensors and weakness of wrist extension and supination for 30 days. The problem commenced on the morning after the patient had slept in a sitting position for 16 hours with his left hand tucked beneath his chin and his elbow and wrist maximally flexed. The next day he noticed complete left finger drop and a partial left wrist drop with weakness of supination of the forearm. Physical examina-

tion revealed paralysis of the extensor indicis proprius, the abductor pollicis longus, the extensor pollicis longus, the extensor digiti quinti proprius and the extensor digitorum communis. In addition there was weakness (but not paralysis) of the supinator and of the extensor carpi radialis brevis. Surprisingly there was also a radial nerve hypalgesia in the distribution of the superficial branch of the radial nerve.

Electromyography revealed delayed nerve conduction over the extensor carpi radialis sling. As the

*The opinions or assertions contained in this paper are those of the authors and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

**Chief, Department of Neurological Surgery, Naval Hospital, Camp Pendleton, Calif. 92055.

***From the Department of Neurological Surgery, Naval Hospital, Camp Pendleton.

+From the Dental Department, Naval Hospital, Camp Pendleton.

++Chief, Department of Physical Therapy, Naval Hospital, Camp Pendleton.

+++From the Department of Physical Therapy, Naval Hospital, Camp Pendleton.

Reprints available from CAPT Frederick E. Jackson, MC, USN, Chief, Department of Neurological Surgery, Naval Hospital, Camp Pendleton, California 92055.

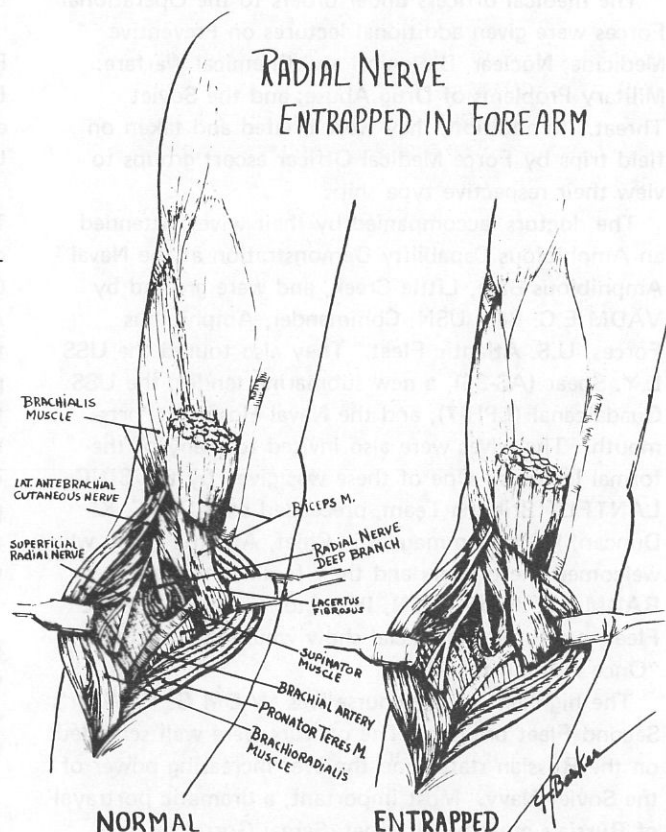
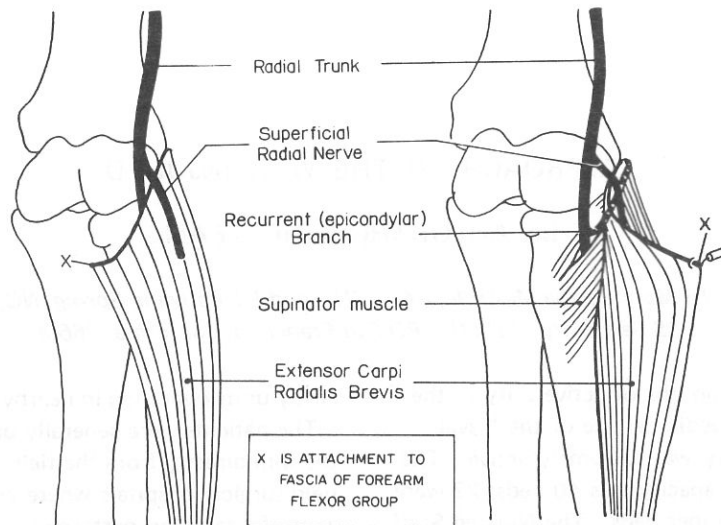


FIGURE 1.



Anatomical relations of radial nerve at the elbow. Note relationship of deep branch to edge of extensor carpi radialis brevis, and its passage into the supinator slit. The recurrent branch may also pass through supinator slit before going to epicondyle. (Modified from Kopell, H. P. and W. A. L. Thompson, *New England J. Med.*, 259: 713-715, 1958.)

FIGURE 2.

patient did not improve with intensive physiotherapy, the upper left forearm was surgically explored. The deep branch of the radial nerve was found to be impinged upon and markedly compressed by the sharp fascial edge of the extensor carpi radialis brevis. The superficial (sensory) branch of the radial nerve penetrated the extensor carpi radialis brevis muscle and then emerged to pursue its course under the brachioradialis muscle. The fascial attachment on the upper margin of the extensor carpi radialis brevis was incised and the nerve decompressed, much as one decompresses the lateral femoral cutaneous nerve for meralgia paresthetica when it is compressed in its course through the inguinal ligament.

Following surgery the patient demonstrated progressive improvement with rapid functional return of the muscles innervated by the deep branch of the radial nerve. The sensory hypalgesia in the distribution of the superficial (sensory) branch of the radial nerve has persisted.

Discussion

The origin of the extensor carpi radialis brevis muscle is from a fibrous root stretching from the epicondyle to the deep fascia over the volar aspect of the forearm.¹ When the deep branch of the radial nerve passes, as it usually does, through a slit in the supinator muscle, it travels immediately under this fibrous origin of the extensor carpi radialis brevis. If this fascial attachment is hypertrophied or if the radial nerve has been placed in stretch for a prolonged length of

time (as in this patient who actually had the nerve and muscle on stretch for 16 hours), the radial nerve may be damaged by external compressive neurorrhaphy. When the function of the nerve has not returned within a reasonable length of time, the nerve may be readily surgically decompressed by slitting the compressive fascial origin over the deep branch of the radial nerve.

Summary

A case of compressive neurorrhaphy of the deep branch of the radial nerve with subsequent clinical improvement has been presented. In this particular case, the prolonged stretch and tension of the extensor carpi radialis brevis muscle itself led to compression with subsequent interruption of function of the sensory branch of the radial nerve and hypalgesia. The usual mode of action of the compressive neurorrhaphy in this area is for the sensory branch to be spared, as it arises shortly before the deep branch of the radial nerve penetrates the supinator muscle. In this particular case, however, the prolonged stretch and tension of the muscle involved directly the superficial sensory branch of the radial nerve.

REFERENCES

1. Kopell, Harvey P. and Thompson, Walter A. L.: *Peripheral Entrapment Neuropathies*, The Williams & Wilkins Company, Baltimore, 1963.
2. Goldman, Sidney; Honet, Joseph C.; Sobel, Robert; and Goldstein, Abe S.: Posterior Interosseous Nerve Palsy in the Absence of Trauma, *Arch Neurol* 21:435-441, 1969.

APPROACH TO THE WAR INJURED

BY AN ORTHOPEDIC TEAM

*By LCDR Mary Cecilia McArdle, NC, USNR and LT Pollyann Spring, NC, USN;
USS Sanctuary (AH-17), FPO San Francisco, California 96601.**

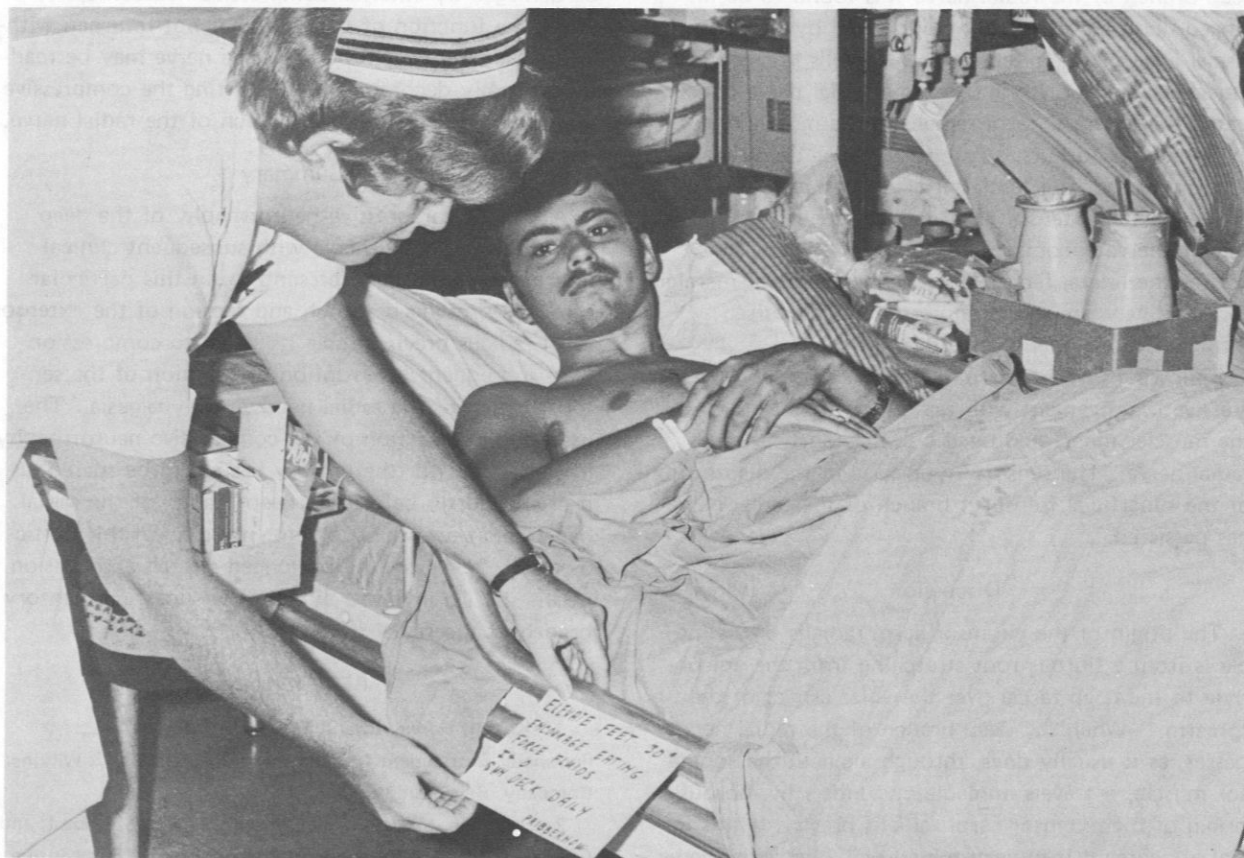
During the last seven months of active duty in the Vietnam area, the Orthopedic Service of the Naval Hospital in USS Sanctuary was extremely active. The major Orthopedic Ward capacity was 40 beds; 22 were lower beds and 18 were upper beds. The Nursing Staff on this specialty ward consisted of two nurses trained in orthopedic nursing, approximately seven general duty relief nurses, one senior ward corpsman and eight to ten junior corpsmen for a 24-hour coverage. In addition to rendering care for personnel of Navy and Marine Corps activities, the hospital ship also supported

Army units operating in nearby areas.

The patients were generally brought by helicopter to the ship directly from the field following injury, or from field surgical hospitals where emergency surgery to sustain life has been performed. Prior to medical evacuation to other areas in the Pacific theater or CONUS, efforts were directed toward stabilizing the clinical condition of patients by appropriate treatment and further operative procedures.

Most of the patients were received on the ward from the triage screening area, the recovery room or the Orthopedic Clinic. Initial physical examinations, radiographic studies, surgical procedures and/or de-

*Received for publication 21 May 1971.



LCDR Mary C. McArdle, NC, USNR attaches Nursing Care Card to bed of E-4 Ernest F. Pribbernuw, USA.



HM3 John W. Smith, USN (left) and LT Pollyann Spring, NC, USN attend patient EO1 Archie B. Coleman, USN.



Orthopedic team confers. Standing from left to right are: LCDR Mary C. McArdle, NC, USNR; HM3 John W. Smith, USN; HM3 Merle Fellows, USN, and; LT Pollyann Spring, NC, USN.

bridement of wounds had been accomplished. Upon arrival on the ward the patient was admitted to a lower bed if severely injured, or to an upper bed if a minor injury had been sustained. Orders were transcribed and a patient care plan was initiated, including a nursing evaluation in addition to the Admitting Doctor's Orders. To facilitate nursing care, plain white 5 x 8 cards were attached to the bed; these cards provided pertinent information relating to specific care of individual patients. Points emphasized included turning times and techniques, position, intake and output, desired frequency of vital sign determinations and circulation checks. The cards proved to be invaluable for relief nurses covering several wards and served a dual purpose as teaching aids for the staff nurses and corpsmen, providing a simple system for follow-through on preparation and demonstration. The cards were reviewed and updated daily by the charge nurse as the patients' orders were changed. This method did not exclude the use of the visible file index, but was employed as an adjunct to the file index.

As part of the admission procedure, patients were bathed, shampooed, and shaved. The ship's barber provided haircuts when patient conditions were favorable. Since most men had spent many months in the "bush" with limited opportunity for maintaining personal hygiene, they appreciated these small luxuries. Each patient was issued an American Red Cross ditty bag containing comfort items for individual use. Since military information for families is necessarily brief, the men were encouraged to make a patch telephone call via "ham" radio to reassure their loved ones at home. Sick call was conducted by the Ward Medical Officers, with the nurse and senior corpsman in attendance, shortly after the morning shift had reported for duty. Each patient was seen and reevaluated; clinical changes since admission or previous sick call were noted. During sick call the junior corpsmen were usually occupied, distributing breakfast trays and feeding patients. Immediately following sick call, the senior corpsman prepared written assignments which were reviewed by the charge nurse and explained to the junior corpsmen. Morning care provided for each patient placed particular emphasis on skin care, positioning, and exercises. Minor dressing changes were performed by ward personnel. Lacking storage spaces, treatment room, and suitable bed arrangement for patient accessibility, major dressing changes were accomplished in the Orthopedic Clinic to which patients were transported by gurney. A physical therapy technician assisted and instructed patients in an exercise regimen which was then followed by ward personnel. Ambulatory patients were often employed to assist

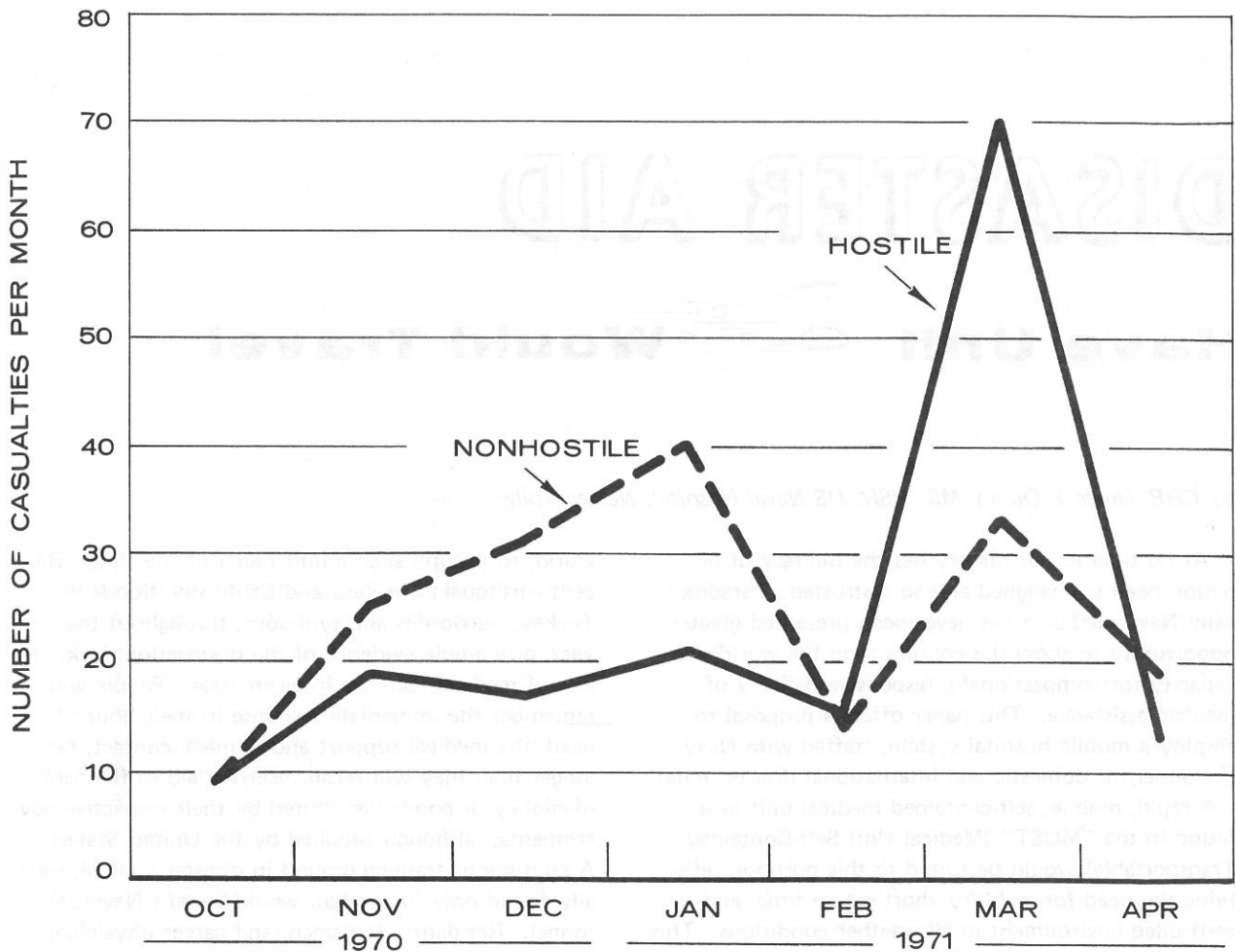
with this detail. They derived great satisfaction from helping their buddies, thereby alleviating some of the staff work load and also their own boredom.

As soon as their clinical condition would allow, patients were introduced to the sun deck which proved a measure of no small importance in promoting morale and motivating men towards recovery. This setting led to an occupational observation of the ship's activities and frequently generated acquaintanceships with members of the ship's company. In spite of their demanding duties, crew members often found time to spend with the wounded. Others played a major role in providing support and untold comfort, and outstanding among them were the Chaplains, Red Cross, Army and Liaison personnel. USO entertainers were occasionally brought aboard the hospital ship to entertain the patients and ship's personnel. For those confined to the ward, diversional activities were provided by closed circuit TV or live talent in the form of a guitar-playing crew member.

Formal and informal instruction periods were conducted at frequent intervals for the ward corpsmen; special attention was given to those corpsmen who had little, or no, prior ward experience. The teaching was provided by the nurses or senior corpsman and was based on guidelines drawn from the Orthopedic Nursing Course given at the Naval Hospital, Philadelphia, Pa. Aside from basic nursing, the nursing staff was continuously trained to recognize normal laboratory studies and alert the doctor to any deviations or unusual developments. Since many injuries were the result of blasting or tearing, massive soft tissue and bone damage were prevalent and there was usually a vast amount of bleeding. Hematocrits and BUN's (blood urea nitrogen levels) were monitored regularly. Patients frequently presented hematocrit values below 35 volumes % and required adequate blood replacement by transfusion before evacuation to other facilities, since blood for transfusion was not generally available on medical evacuation flights. Elevated BUN determinations often signaled adverse effects of antibiotics and were carefully investigated. The importance of cultures obtained from wounds, to assist medical officers in determining the proper administration of antibiotics, was emphasized. Appropriate reports were immediately transmitted to the doctor.

The effectiveness of a hospital ship in a combat zone has been tested and proven by the vast numbers of casualties treated and the impressive mortality-morbidity statistics. The enlisted Orthopedic ward alone received 108 patients during the month of March, 1971. Figure 1 indicates the number of hostile and nonhostile casualties received during the time period

FIGURE 1



Admissions to the orthopedic ward, Naval Hospital in USS Sanctuary (AH-17).

from October 1970 through April 1971. The low figure shown for the months of October and February reflect the fact that during part of each of these months SANCTUARY retired briefly to Subic Bay, R.P. for replenishment and repairs. The marked increase in hostile-fire combat casualties during the month of March accompanied increased activity at the Laotian border. The majority of these casualties presented fragmentation injuries from mines and other explosive mechanisms. Approximately 17% of the total admissions were not directly related to combat.

Highly motivated personnel made substantial con-

tributions to the care of the war injured. An historic era in Navy medicine closed as a "Great Lady" lowered her sails. USS Sanctuary departed Vietnam station in early May, arriving at Vallejo, Calif., in early June. The Naval Hospital in SANCTUARY was decommissioned 15 July 1971 and is being deactivated.

REFERENCES

1. Daily Patient Personnel Reports, USS Sanctuary (AH-17).
2. Ward Manual, USS Sanctuary.
3. Fourth Conference on War Surgery, Commander in Chief Pacific, Tokyo, Japan; February 1970. 🇺🇸

DISASTER AID

Have Unit Would Travel

By CDR James J. Quinn, MC, USN; US Naval Hospital, Naples, Italy.

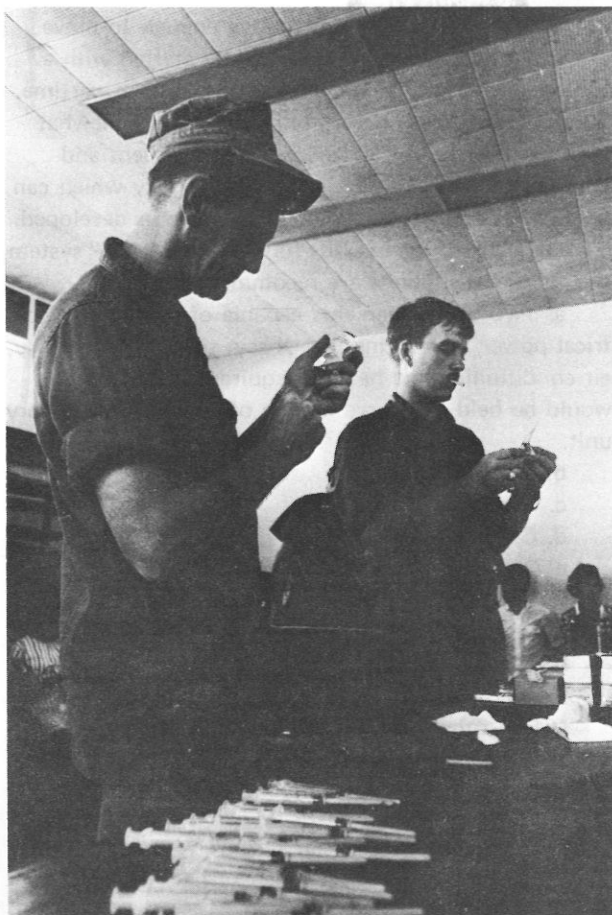
At no time in our history has the military of our nation been so maligned and so distrusted. Paradoxically Navy medicine has never been presented greater opportunity to show the country, and the world, our capacity for compassionate, responsive delivery of medical assistance. This paper offers a proposal to employ a mobile hospital system, staffed with Navy personnel, for domestic and international disaster relief.

A rapid, mobile, self-contained medical unit as is found in the "MUST" (Medical Unit Self-Contained Transportable) would be suited to this purpose, satisfying the need for mobility, short set-up time, and controlled environment in all weather conditions. This ready-packaged unit can be transported anywhere in the world, at any time, by almost any means of transportation. The lack of landing and unloading facilities in disaster areas might be overcome, with time and experience. Transportation of the proposed unit from an air field to a distant point might require, for example, the use of M35 trucks or an H53 helo lift, with the fuel supply needed to run these vehicles. Expertise in these matters could be acquired.

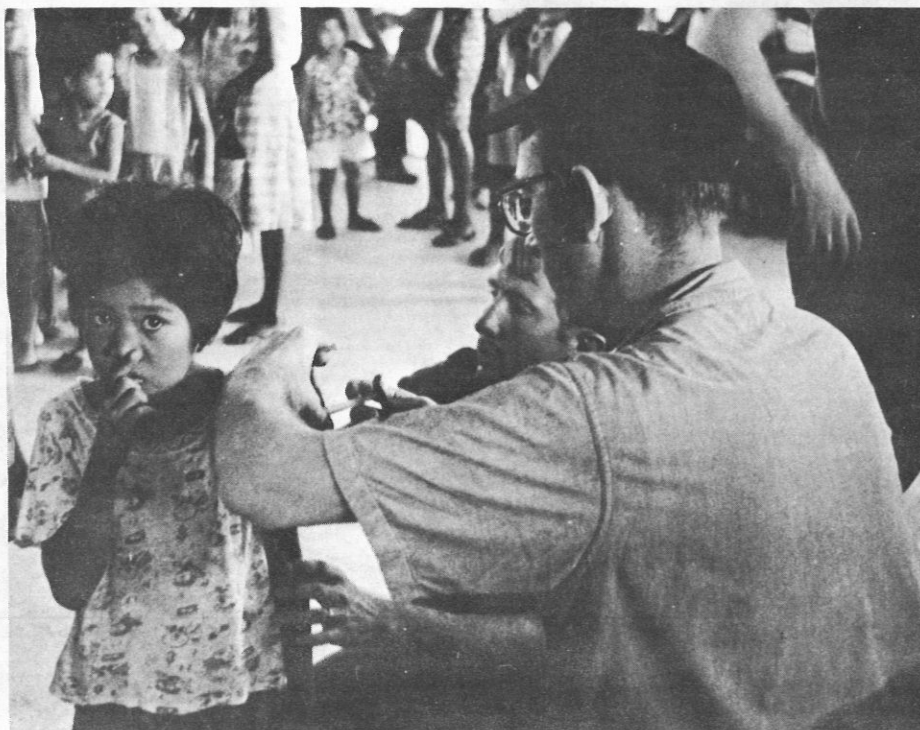
Regardless of his race, creed, color, culture, religion or ideology, an individual confronted with a life-threatening situation feels desperation. There is an obvious advantage in acquiring the capacity to respond to such a need within hours, to report anywhere in the world within 24 hours, and to become operational within a total time of 48 hours. There are a sufficient number of disasters in this country, as well as in the

world, to occupy such a unit much of the time. Recent earthquakes in Peru and California, floods in Turkey, hurricanes and typhoons, throughout the year, give ample evidence of the destruction, lack, and loss of medical facilities in given areas. People will remember the immediate response in their hour of need, the medical support and humane contact, far longer than they will recall receiving aid in the form of money or goods distributed by their respective governments, (although supplied by the United States). A continuous training ground in disaster control, usually found only in combat, would benefit Navy personnel. Residents, corpsmen, and career physicians could surely profit from the field training and experience that mass casualty operations would provide. It is difficult to simulate disasters, civilian or military, and most exercises provide meager medical education at best.

Considerable coordination would be required: with the Department of Defense for rapid transportation, with the Department of State for use in international disasters, and with the Office of Emergency Preparedness for national disasters, for example. The initial cost of equipment would probably exceed one million dollars. The unit itself might well be considered an integral part of a large teaching hospital; the manpower, assigned into teams could be drawn from the hospital staff. Others might propose that such a unit be created as an integral part of a Marine Division, but I feel this may restrict its use as a teaching base. Medi-



In November 1970, NAVY HOSPITAL CORPSMEN ASSIST VICTIMS OF TYPHOON JOAN, in the Philippines.



cal battalions are really not mobile enough to move out in 24 hours, nor are they usually staffed with a full complement of medical officers, except in wartime. Surgical teams with mount-out blocks are somewhat limited in capability, total scope of treatment and equipment. A truly mobile medical facility which can be rapidly and easily transported is yet to be developed.

Based on the type of units found in a "MUST" system, the following subunits are recommended:

- a. Two utility elements capable of supplying electrical power for routine use, X-ray, surgery, laboratory, air conditioning and heating requirements. One unit would be held in reserve in case of failure of a primary unit.
- b. One X-ray element
- c. One laboratory element
- d. One pharmacy element
- e. One CSR element
- f. One surgical element
- g. One combined ortho-dental unit
- h. Two ward units
- i. One dispensary or triage element
- j. Two other ward elements would serve as staff quarters and galley space.

The suggested combination of subunits should prove adequate for travel anywhere, providing a complete hospital, ready for all types of cases. The unit would be suitable for use in the same manner that our medical battalions have been employed in Vietnam.

Proposed personnel would include the following: one orthopedic surgeon, one general surgeon, one anesthesiologist or male nurse anesthetist, one trained general practitioner, one internist, one or two GMO's (General Medical Officers), one dentist, one Medical Service Corps officer, one Chief Hospital Corpsman, one PMU (Preventive Medicine Unit) technician, one X-ray technician, two laboratory technicians, three OR technicians, one dental technician, fourteen General Service corpsmen and six Marines (for security/mess duty/labor). While it is recognized that this would represent a large undertaking, and that alternate or relief personnel would have to be provided, the value of the program would surely justify the cost. It is envisioned that the proposed unit would be committed to a maximum use of 30 consecutive days.

The Navy Medical Department represents a dedicated career body which has benefited from experience gained in providing medical support of the US Marine



Ravages of Hurricane Celia at Naval Hospital, Corpus Christi, Texas, in August 1970.



Crew chief aboard a Marine C-46 helicopter held young Peruvian girl being taken to USS GUAM for medical aid in June 1970.

Corps, and fleet operations. The proposed program could offer the greatest training plan ever devised for teaching residents, with organized training in trauma, tropical diseases and unique emergencies rarely encountered elsewhere. I fully realize that my proposal is not unprecedented or remarkably novel. But perhaps the climate has changed, and national sympathies toward humanitarian endeavors at home and abroad are currently stronger. The time may now be right for serious consideration of such a program.

This is a short, rough outline of a conceptual proposal to establish a dynamic foundation for rendering a valuable service and providing vital experience in team management of casualties. A secondary gain might be realized by altering the military image from a wartime spectre to that of a humane healer. Perhaps someone will be stimulated to actively pursue such a project at the policy level.

Acknowledgement: I am indebted to CAPT J. H. Stover, Jr., MC, USN, for his advice and comments.





Three Navy surgical teams were deployed aboard USS GUAM (LPH-9) to aid in relief operations following the devastating earthquake in northeast Peru on 31 May 1970. Some victims were taken aboard GUAM for medical treatment commencing on 13 June 1970. 🇺🇸

THE HEMATOLOGISTS' CORNER

The Hematology/Oncology Service, Naval Hospital, Philadelphia sponsors a one-year training program in Medical Oncology either as a third-year subspecialty elective of a three-year residency training program or upon completion of an approved residency program.

Dr. Suvari, a coauthor of this article, is currently rotating in Medical Oncology.

Further information concerning this program may be obtained by contacting CAPT Burningham, MC, USN, Naval Hospital, Philadelphia, Pa.

CANCER CHEMOTHERAPY

By CDR Neal J. Prendergast, MC, USN; LCDR Agu Suvari, MC, USNR, and; CAPT Richard A. Burningham, MC, USN; Hematology/Oncology Branch, Medical Service, Naval Hospital, Philadelphia, Pennsylvania.

Disseminated or inoperable malignancy remains the most devastating and challenging of all human illnesses. In spite of many encouraging advances in the epidemiology, pathophysiology, and chemotherapy of cancer, many clinicians retain an attitude of helplessness and defeatism when confronted with a cancer patient. It is not generally realized that even in the seemingly hopeless cases, the medical oncologist has much to offer the patient in terms of emotional and physical comfort with improved quality and/or length of survival. Here we would like to review the role of chemotherapy in the management of malignant disease, mentioning some of the highlights of recent developments in the field of Medical Oncology.

In general, chemotherapy is reserved for the treatment of advanced disease where surgery and/or radiation are no longer practical. Because chemotherapy is usually only palliative, it is generally withheld until symptoms or complications ensue. On the other hand, since six to twelve weeks are required for significant anti-tumor effect of most agents, chemotherapeutic intervention should not be postponed until the patient is moribund. As a rule, candidates for chemotherapy should have a survival expectancy of two to three months. In most instances, the patients, as well as their relatives, should be aware of the diagnosis and prognosis, the nature of the drug therapy, and potential benefits as well as complications to be expected.

The anticipated effectiveness of chemotherapy will vary with tissue type and with individual patients. In some instances very prolonged survival or even cures

are attainable (Table I). Gestational trophoblastic tumors (choriocarcinomas) are 70% curable with methotrexate, actinomycin-D, and vinblastine. Burkitt's lymphoma shows a 50% cure rate with alkylating agents such as cyclophosphamide. Two to three percent of disseminated testicular tumors are curable with combination chemotherapy (actinomycin-D, methotrexate, chlorambucil). Chemotherapy, combined with surgery and radiotherapy, may cure one-third of Wilms' tumors and 5% of neuroblastomas.

Chemotherapeutic palliation, defined as objective evidence of regression in measurable tumor with improvement in patient comfort and performance status, combined with prolongation of life, is possible in a variety of common neoplasms such as: acute lymphoblastic leukemia (80-90%), prostatic carcinoma (70%), breast carcinoma (20-40%), chronic lymphocytic leukemia (50%), lymphosarcoma (50%), and Hodgkin's disease Stages III and IV (80%).¹

In other instances definite palliation in terms of tumor regression and patient comfort is attainable without definite prolongation of life. Such examples would include: chronic myelogenous leukemia, multiple myeloma, testicular carcinoma, and ovarian carcinoma.

Available standard chemotherapeutic agents are of questionable benefit in cancers of lung, head and neck, bowel, stomach, pancreas, liver, adrenal cortex, and in melanoma. However, even in these instances, one often sees dramatic exceptions to the rule which justify a trial of drug therapy. Even when the probability of tumor response is remote, ancillary benefits to the patient — such as "a ray of hope," frequent contact with an interested physician, closer attention to related complications and comfort, and accessibility

The opinions expressed herein are those of the authors and cannot be construed as reflecting the views of the Navy Department or of the naval service at large.

TABLE I

AGENTS PRESENTLY AVAILABLE TO THE CLINICIAN
FOR TREATMENT OF SOLID TUMORS (1)

TUMOR TYPE	DRUG	% CURE (C) / PALLIATION (P)
1. Trophoblastic Tumors (Choriocarcinoma)	Methotrexate Actinomycin-D Vinblastine	70% (C)
2. Burkitt's Lymphoma	Cyclophosphamide	50% (C)
3. Testicular Tumors	Actinomycin-D Methotrexate Chlorambucil (In Combination)	2-3% (C) 30-40% (P)
4. Wilms' Tumor	Actinomycin-D with surgery/ irradiation	30-40% (C)
5. Neuroblastoma	Cyclophosphamide with surgery and/or irradiation	5% (C)
6. Prostatic Carcinoma	Estrogens with castration	70% (P)
7. Breast Carcinoma	Androgen/estrogen, 5-Fluorouracil, alkylating agents	20-40% (P)
8. Ovary	Alkylating agents	30-40% (P)
9. Endometrium	Progestins	20-30% (P)
10. Lung	Alkylating agents	30% (P)
11. Head and Neck	Alkylating agents, methotrexate	25% (P)
12. Colon	5-Fluorouracil	10-20% (P)
13. Stomach	5-Fluorouracil	10% (P)
14. Pancreas/Liver	5-Fluorouracil	10% (P)
15. Cervix	Alkylating agents	10% (P)
16. Melanoma	Alkylating agents, Vinblastine	5% (P)

to latest developments — usually outweigh any potential hazards of chemotherapy.

Recent breakthroughs in cancer chemotherapy have not only included new agents but more effective ways of using older, well-known drugs. Combination chemotherapy using multiple drugs with different mechanisms of action has significantly improved response rates in a variety of neoplasms, some of which have already been mentioned. It is now accepted that the treatment of choice in acute leukemia is multiple drug therapy during remission induction, intensification, and maintenance. Encouraging response rates of up to 80%, with 50% five-year survivals, are seen in advanced Hodgkin's disease using nitrogen mustard (Mechlorethamine), vincristine (Oncovin), prednisone, and procarbazine (MOPP program).² Advanced breast cancer, unresponsive to hormonal manipulations, has been reported to show a good response rate to combinations of cyclophosphamide, vincristine, prednisone, 5-fluorouracil, and methotrexate.³ Modification of the dose of 5-fluorouracil to a weekly schedule has recently been shown to greatly reduce its toxicity, without apparent sacrifice in response rates, in a variety of carcinomas.⁴

There are many new agents currently being investigated for antitumor activity. Bischloroethyl-nitro-

sourea (BCNU), a new alkylating agent, has shown promising effectiveness in Hodgkin's disease and melanoma. Because BCNU is lipid-soluble, it has shown some potential in the management of CNS (Central Nervous System) tumors. Some of the newer anti-tumor antibiotics may be quite useful. Adriamycin may be effective in acute lymphoblastic leukemia and lacks the cardiac toxicity of daunomycin to which it is structurally related. Bleomycin, which lacks significant hematologic toxicity and concentrates in keratin-forming tissue, would appear to be effective in the treatment of squamous cell carcinomas, especially of the head and neck. The latter drug has also been reported to offer promise in the management of testicular tumors and Hodgkin's disease.⁵

The development of new drugs and better understanding of older agents are no more important than efforts to improve ancillary supportive care. It is evident that facility in handling the side effects of chemotherapy must be acquired if survival is to increase. Recent sophistication achieved in blood bank techniques has greatly enhanced the clinician's ability to improve cancer-patient care. The general availability of component blood transfusions has allowed the physician to accept greater degrees of hematopoietic toxicity, furthering the use of toxic agents to their full advantage.

TABLE II
SOME CURRENT CHEMOTHERAPEUTIC PROGRAMS UNDER INVESTIGATION BY ECOG

TUMOR TYPE	AGENTS
1. Lung	Cytosan (two dosage schedules) Irradiation and Hydroxyurea/Procarbazine Nitrogen mustard, methotrexate with or without Bleomycin — disseminated disease (proposed study)
2. Breast	5-Fluorouracil and Premarin Bleomycin/CCNU ¹ /Streptozotocin in disseminated disease (proposed study)
3. Colon/Rectum	Procarbazine/Streptozotocin/CCNU ¹ /Bleomycin 6-Thioguanine/Procarbazine 5-Fluorouracil vs. 5-Fluorodeoxyuridine (Intravenous) (Intra-Arterial, Hepatic)
4. Kidney	Provera/Hydroxyurea/Nafoxidine
5. Prostate	Melengestrol
6. Melanoma	BCNU ² /DTIC ³ /Vaccina Immunotherapy
7. Phase 1 studies with various tumor types	Bleomycin/Estradiol Mustard/Phenestrin/5-Azacytidine/Hexamethyl Melamine

¹CCNU = chloroethyl-cyclohexyl-nitrosourea

²BCNU = bis-chloroethyl nitrosourea

³DTIC = Dimethyltriazeno Imidazole Carboxamide

TABLE III

SOME CURRENT CHEMOTHERAPEUTIC PROGRAMS
UNDER INVESTIGATION BY ALGB

TUMOR TYPE	AGENTS
1. Primary brain tumors in childhood	Intrathecal methotrexate, vincristine, BCNU, dexamethasone
2. Malignant solid tumors of childhood resistant to standard chemotherapy	Adriamycin
3. Inoperable breast cancer	Vincristine, prednisone, 5-fluorouracil, methotrexate, and cyclophosphamide in three- or five-drug combination
4. Neuroblastoma	Vincristine and Cytosan, or Matulane and Cytosan


The infectious complications of disseminated malignancy or its treatment are no less lethal than the disease itself. These complications can best be managed through improved prevention, early recognition, and effective therapy. Recently developed reverse isolation techniques, including Life Island units and laminar air flow units, are useful in the prevention of exogenous infection. New antimicrobial drugs such as carbenicillin, gentamicin, pentamidine, and 5-fluorocytosine show promise in treating the opportunistic and virulent superinfections that so regularly kill patients who are immunologically suppressed. It is important to realize that it is difficult to justify the use of very toxic drugs where ancillary support of the type described is unavailable.

Cooperative chemotherapy groups, such as the Acute Leukemia Group B (ALGB), and the Eastern Cooperative Oncology Group (ECOG), have shown the necessity for strict evaluation of treatment regimens under protocol conditions, on large numbers of patients. Tables II and III list certain protocols that are currently under investigation by these groups. New protocols are being continuously activated to expand this list. The results of these strictly controlled cooperative studies have been gratifying. The Hematology/Oncology Department of the Naval Hospital, Philadelphia, holds membership in both of these cooperative groups. Through this membership considerable up-to-date information concerning the therapeutic efficacy of various treatment regimens is made available and newer chemotherapeutic agents have become accessible for clinical trial. There is considerable potential for greater Navy participation in these pro-

grams. Such participation would significantly add to a growing fund of information and enhance our ability to cope with this major medical challenge. In addition there is every reason to believe the Navy could develop its own cooperative effort in certain areas of clinical investigation within the cancer research field.

It is becoming increasingly apparent that the rapid developments in cancer therapy have led to the formation of a new specialty, Medical Oncology. There is a growing need for physicians broadly trained in the total management of malignant disease. Special training is indicated in pathology, biochemistry, pharmacology, cellular kinetics, infections, and metabolic disease. The American Board of Internal Medicine now recognizes Oncology as a separate subspecialty and will shortly conduct examinations for certification in this challenging field.⁶

REFERENCES

1. Krakoff, I. H.: The Present Status of Cancer Chemotherapy. *Med Clin North Am* 55:3, 683-701, 1971.
2. De Vita, V. T., Serpick, A. H., and Carbone, P. P.: Combination Chemotherapy in the Treatment of Advanced Hodgkin's Disease. *Ann Int Med* 70:6, 881-895, 1970.
3. Cooper, R. B.: Combination Chemotherapy in Hormone Resistant Breast Cancer. *Proceedings of the American Association of Cancer Research*, 10:15, 1969.
4. Horton, M. B., Olson, K. B., et. al.: 5-Fluorouracil in Cancer, An Improved Regimen. *Ann Int Med* 70:6, 897-900, 1970.
5. Rosenbaum, C., and Carter, S. K.: Bleomycin Clinical Brochure. National Cancer Institute, March, 1970.
6. Kennedy, B. J.: Oncology in Medicine, edit. *Ann Int Med* 70:4, 637-639, 1970. 

DENTAL EMERGENCIES IN CHILDREN

*By LCDR Sheldon M. Bernick, DC, USNR-R**
1230 Burmont Road, Drexel Hill, Pa. 19026

A mother hysterically tells your receptionist that "Johnny just fell at the swimming pool and broke one tooth; another is almost out of his mouth and he is covered with blood." Or, "Susie just fell off her bicycle, broke her tooth, and is in terrible pain."

Traumatic injuries to the dental structures are real emergency situations. It is true that they are not life threatening, but they are painful in most instances and parents are extremely upset, not only because of the child's pain, but also because of the future cosmetic implications.

The pediatrician, therefore, should know the capable dental personnel in his area that are able to cope with these situations. A pedodontist (pediatric dentist) is probably best able to handle the hysterical parent and child as well as the emergency. The oral surgeon and general dentists can also be helpful in alleviating pain and successfully treating the injured structures.

The first procedure in management is to reassure the parent that everything will be done for the child that is possible. The child should be brought to the dental office immediately. If the parent is distraught these feelings will be communicated to the child, thereby increasing the problem of treatment; and a distraught child can further upset the parent.

The sooner the injured teeth are treated, the better the prognosis. The dentist will perform a thorough examination of the injury, eliciting a history of the accident and conducting appropriate radiograph studies. A medical history should also be obtained to alert the dentist to any medical complications.

*Assistant Clinical Professor, University of Pennsylvania, School of Dental Medicine; Assistant Dentist, Children's Hospital of Philadelphia, and; Consulting Pedodontist, Naval Hospital, Philadelphia, Pa.

The opinions and assertions contained herein are those of the author and are not to be construed as official or as reflecting the views of the Navy Department or of the naval service at large.

Pain should be alleviated with drugs, since a child without pain will be in a better position to cooperate with the treatment. Local anesthesia should be used to alleviate pain; epinephrine incorporated in the anesthetic solution will help control hemorrhage. Sedative and tranquilizer drugs may help to calm both child and parent.

Varied and different types of injury to the oral structures are encountered — soft tissue lacerations and bruises, injured primary and permanent teeth. Each category will be considered here in some detail. If it appears likely that infection from the wound or environment will result, appropriate antibiotic therapy should be instituted and cultures obtained. In all oral injuries tetanus prophylaxis is also advisable.

Soft Tissue Injuries

Lacerations of the oral mucosa and structures often occur, usually associated with injuries to the teeth, or as a direct result of imbedding the teeth into tissue. The lips, frenum of the tongue, labial mucosa, and buccal mucosa can be deeply lacerated due to contact of the teeth with hard objects, or from biting. Likewise the tongue itself may be lacerated.

It is best to let healing take place spontaneously in the case of shallow lacerations, instructing the parent to keep the wound clean with a mild hydrogen peroxide solution.

Wound débridement procedures should be used in treating deep lacerations, after the area has been infiltrated with a local anesthetic agent. Nonviable tissue should be excised and fresh wound edges opposed with either 000 silk or chromic sutures. Sutures should not be too tight, but the knots should be well tied to prevent premature loosening by tongue and lip activity.

In deep facial and vermilion border of the lip lacerations, wound débridement and suturing are indicated. Parents should be told about scarring and the possible need for cosmetic revision.

Injuries to the Primary Teeth

From the time the child learns to stand he becomes vulnerable to injury. The lack of experience and coordination are the major causes of these injuries. The largest number of oral injuries occur in children with a protrusion of incisors, usually due to habits of extensive pacifier use, tongue thrust and finger sucking. The extent of injury is in proportion to the angle and force encountered in the fall. There are various categories of trauma to the teeth, and each has a definite type of treatment.

Fracture involving enamel only is best treated by smoothing the sharp edges of the fracture and applying a protective varnish to help prevent irritation to the tongue. If the fracture involves both the dentin and enamel, a sedative treatment is applied over the fracture and a protective stainless steel crown or band is used, much like a Band-Aid, to prevent further injury and thermal irritation. If the pulpal tissue is exposed by a fracture, a therapeutic pulpotomy is performed and a crown placed. Since it is very difficult to treat a fractured root in a primary tooth, removal of the tooth and root fragment is indicated, taking care not to injure the developing permanent teeth.

Intrusion of the teeth is usually encountered when a tooth is displaced, due to the immaturity of the supporting bone. A period of watchful waiting is indicated, for these teeth tend to reerupt in three to four weeks. If no reeruptions occur or if a fistula develops, the tooth will have to be extracted. It should be remembered that excessive swelling around the tooth makes the degree of intrusion appear worse than it actually is. If the displacement is to the lingual or labial (usually in lower incisors) aspect, the teeth can be

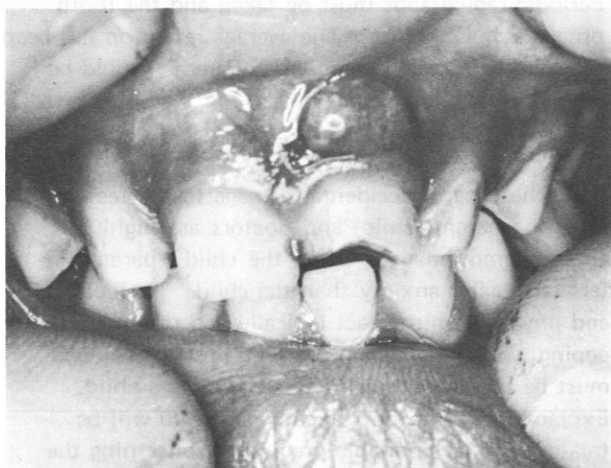
repositioned and splinted in place with a variety of appliances, for a period of four to six weeks.

In complete avulsion of a primary tooth, attempts to replant the tooth are usually contraindicated. The chance of success is limited by the emotional state of the child, difficulty of fixation and resorption of the root. Attempted replants of the primary teeth can also damage the developing permanent successors, resulting in hypoplastic defects, malformed roots or/and interrupted eruption sequence. If successful, the replanted primary tooth usually becomes ankylosed to the bone and will have to be removed surgically to make way for the successor. A prosthetic device, either fixed or removable, can be placed to restore reasonable function and cosmetic appearance, to maintain space, and prevent abnormal tongue habits. Children wear these appliances with little difficulty and are usually quite proud of their "false tooth".

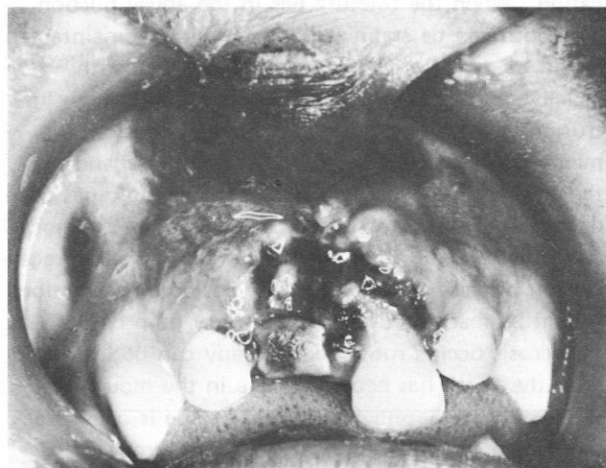
Primary teeth that have become discolored or darkened are usually assumed to be nonvital. This is not always the case. The dark color could represent the black and blue reaction of oxidized hemoglobin, and if the blood supply is adequate, color will reappear. Occasionally the tooth will remain dark but retain vitality. If a fistula, boil, redness or swelling appear, the tooth should receive pulpal therapy or be removed. Fever is often related to nonvital primary teeth. Infections of these teeth should be considered in children who present fever of unknown origin.

Injured Permanent Teeth

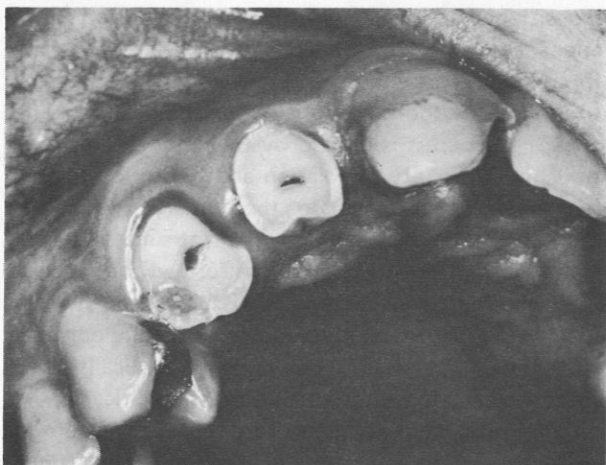
The large central incisors are usually most vulnerable to injury since they receive little support from adjacent teeth to absorb the force of a blow, and, in the younger patient the roots are not completely formed. This vul-



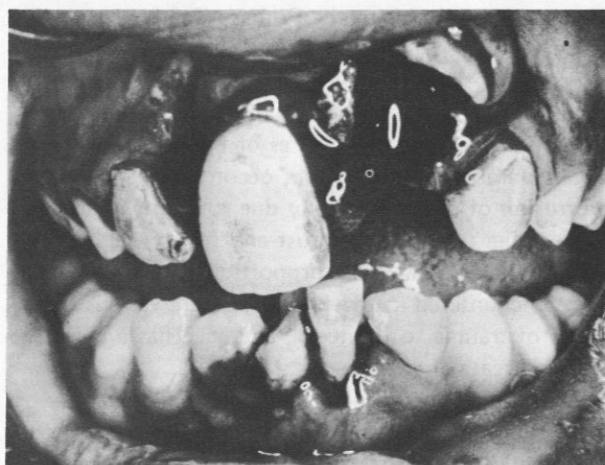
Fractured upper primary incisor and resulting fistula ("gum boil"); age 4.



Traumatized primary teeth — upper right central incisor is completely avulsed; upper left central incisor is extruded. Note hematoma of soft tissue; age 4.



Fractured upper lateral incisor and cuspid involving enamel, dentin, and pulpal tissue; age 13.



Traumatized permanent teeth: Upper right central incisor is partially extruded; upper left central incisor is intruded. Fractured and displaced lower incisors; age 11.

nerability increases with abnormal tongue habits or thumb sucking, causing these teeth to protrude.

Enamel and dentin fractures are treated in the same way as was noted with primary teeth. Restorations to improve function and cosmetic appearance can be placed in six months, when it has been determined that no further dental damage has been suffered.

In a fracture where the pulpal tissue is exposed, a vital pulpotomy is performed on teeth which have not fully matured to root closure. In an older child, the treatment of choice is a full pulpectomy and root canal therapy. Esthetic restorations can be placed after it is determined that the tooth has "healed."

When the root has fractured, several possibilities of treatment are presented depending on the fracture location. When the fracture lies in the apical portion, the tooth can be stabilized and the vitality maintained. If the fracture lies in the coronal 1/3, the tooth usually has to be extracted. When labial, lingual, intrusion or extrusion displacement has occurred, the maintenance of vitality in the tooth will depend on the extent to which the tooth's blood supply has been damaged. The tooth should be realigned in position and stabilized for a period of six weeks to allow regeneration of the periapical tissues. Periodic observations should be made to detect evidence of pulp necrosis. If necrosis occurs root canal therapy can be instituted after the tooth has become stable in the mouth.

In tooth displacement the labial bone is often fractured. No attempt should be made to remove this bone. Splinting the teeth and suturing the lacerations help to promote the healing of this area.

In a complete avulsion of the tooth, the parent

should be advised to replace the tooth into the socket and bring the child to the office as soon as possible. If the parent has reservations about his ability to do this, the tooth should be wrapped in a clean, moist cloth and brought to the dentist to replant. Time is of the utmost importance here, because the periodontal fibers on the cementum of the tooth may be able to proliferate and form a normal attachment, if the tooth is quickly replanted. The dentist will replant and splint the tooth immediately with little manipulation. If several hours have elapsed since the accident, endodontic treatment is indicated before the tooth is replanted. In six to eight weeks the splint is removed and the tooth evaluated for mobility. In many cases root resorption will take place, in time. Periodic radiographs must be taken and the tooth observed for mobility. The average retention has been reported to be about ten years. Parents should be advised of the prognosis.

Summary

At the time of accidental damage to the teeth and face, the parent, child, and doctors are highly charged emotionally. Often the child's parent suffers far greater anxiety than the child. The dentist and physician must react logically and rationally in coping with the emergency situation. Reassurance must be provided to calm the parents and child. Explanations as to how exactly the child will be treated, and a reasonable prediction concerning the possible consequences, are required. The speed with which treatment is instituted is most important for a favorable prognosis.

REFERENCES

Ellis, R. G.: The Classification and Treatment of Injuries to Teeth of Children. Yearbook Publishers, ed. 4, Chicago, 1969.

Finn, S. B.: Clinical Pedodontics. W. B. Saunders, ed. 2, Philadelphia, 330-361, 1966.

Hawes, R. R.: Traumatized Primary Teeth. Dent Clin North Am 10:391-404, 1966.

Rabinewitch, B. Z.: The Fractured Incisor. Pediatr Clin North Am 3:979-981, 1956.

Robbins, M. B.: Injuries to the Primary Teeth. Dent Dig. Jun., 1967. ☞

CHAMPUS ALLOWS SOME DENTAL CARE

Dental care, though limited, is authorized under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

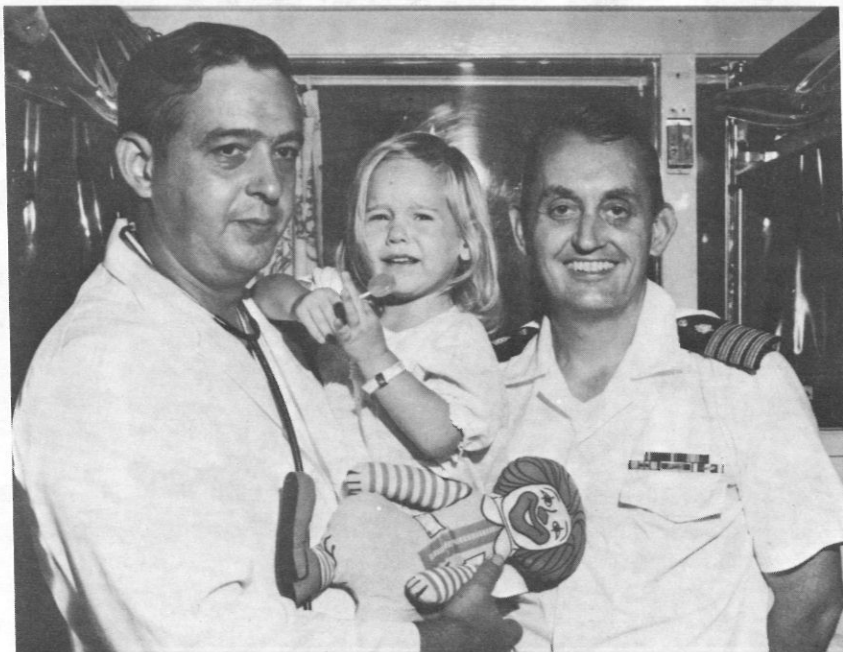
For example, if a CHAMPUS beneficiary is a diabetic and in the opinion of the attending physician and

the dentist the elimination of dental infection will help in the treatment and control of the diabetes, then such dental care would be authorized.

Claims for adjunctive dental care are submitted on the same form used to submit claims for care provided by physicians and other medical personnel. The claim must be accompanied by a statement from the physician outlining the patient's primary diagnosis and attesting to the necessity for dental care in the treatment of that condition.

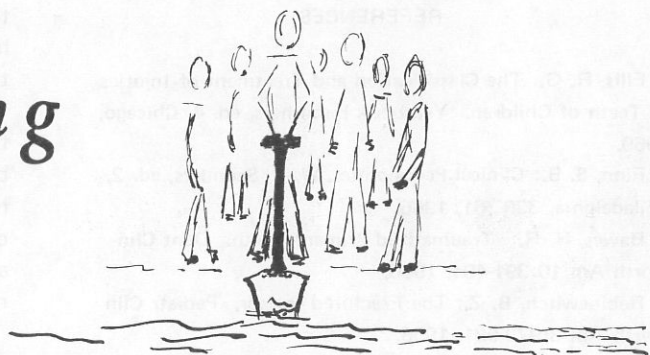
Unlike claims for most services, however, dental claims are submitted to the CHAMPUS office, Denver, Colo. 80240, for payment and not to the fiscal agent for the state in which the care was provided.

In addition to adjunctive care, other dental services authorized under CHAMPUS include the removal of pulp and restoration of teeth in the case of wounds, fractures, lacerations and dislocations. Also, through the Program for the Handicapped, dependents of active duty personnel are eligible for orthodontic care necessary to treat severe malocclusion. — Washington, AFPS. ☞



A pleasing veteran of open heart surgery, little Amy Adams is shown consulting with two of her very special physicians: Pediatric Cardiologist CDR Albert C. Price, MC, USN (left), and: CAPT Mitchell Mills, MC, USN (right), Chief of Cardiothoracic Surgery at the Naval Hospital, NNMHC, Bethesda, Md. ☞

Groundbreaking



Literally speaking.....

Ground was broken for the new nine-story, 600-bed Naval Hospital at Camp Pendleton, Calif., on 13 May 1971. Existing hospital buildings will be demolished after the new structure is occupied. Medical and surgical inpatient care facilities will be located on the second through eighth floors of the new hospital which will be completely air conditioned, with modern communications and automated central transportation systems for supplies and trash disposal.

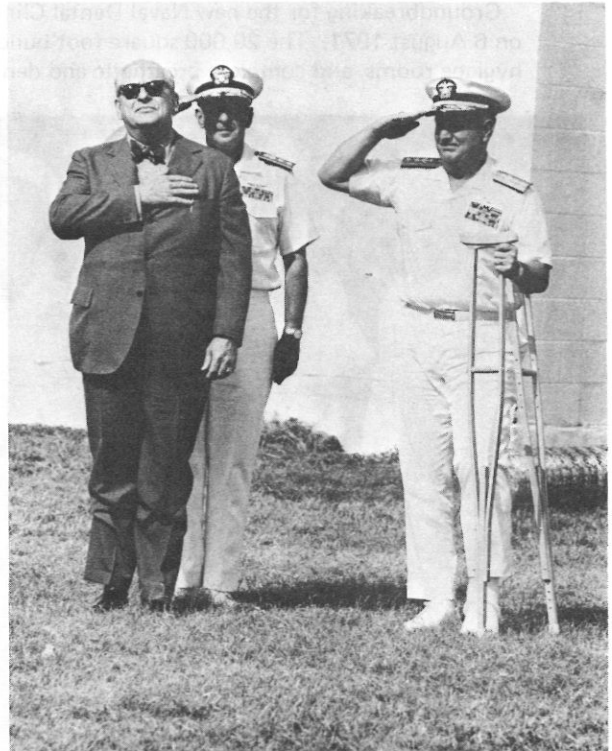
Ground was broken for the new six-story, 195-bed Naval Hospital at NAS Corpus Christi, Tex., on 21 May 1971. Another new facility to be added to the Naval Hospital location will be an Aviation Physiology Training Unit with rapid decompression chamber for altitude training. A vertical lift will deliver supplies from the new hospital's central surgical supply; pneumatic linen and trash systems will be included in the new structure which will be located next to the present hospital.



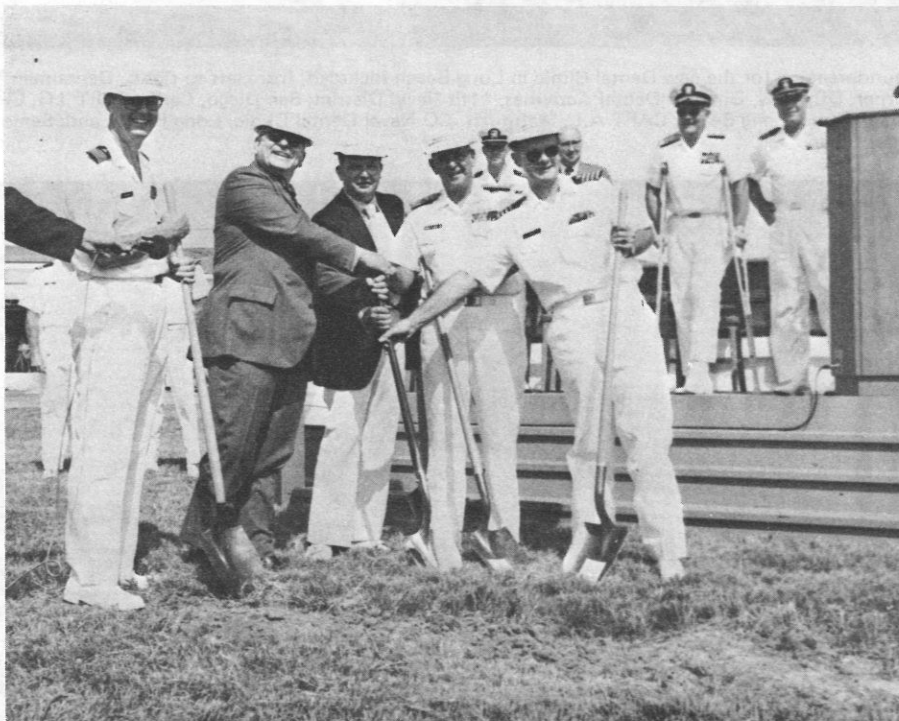
Six shovelfuls of earth were turned to mark the beginning of construction of the new Camp Pendleton Naval Hospital during groundbreaking ceremonies May 13. Participating in the ceremony are, from left to right: MAJ GEN George S. Bowman, Jr., Camp Pendleton Base Commander; RADM John W. Albright, MC, USN, Deputy Chief, Bureau of Medicine and Surgery; RADM Horace D. Warden, MC, USN, 11th Naval District Medical Officer and Commanding Officer of U.S. Naval Hospital, San Diego; James W. Sink, Vice President of William L. Pereira Associates, who designed the new hospital; and CAPT G.M. Ricketson, Commanding Officer of the Naval Hospital, Camp Pendleton.



RADM Albrittain and CAPT Ricketson cut a cake in the design of the new hospital.



U.S. Rep. John Young (left); RADM Oscar Gray, Jr., MC, USN, CO, Aerospace Medical Center at Pensacola, Fla., (center), and; RADM Billy D. Holder, USN, Chief Naval Air Advanced Training, (right), were among participants at groundbreaking ceremonies for the new Naval Hospital at NAS Corpus Christi, Tex.

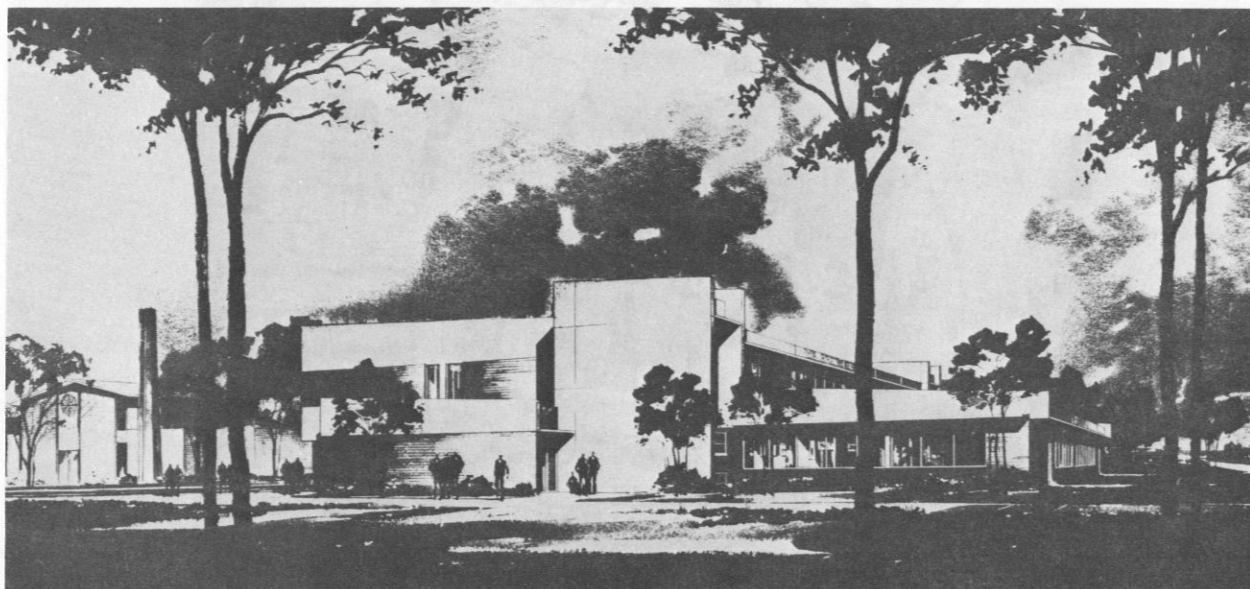


Standing, from left to right are: CAPT Howard A. Baker, MC, USN, (now retired), CO Nav Hosp Corpus Christi; Texas Congressman John Young, Guest Speaker; J. Fulton, President, Burnett Construction Co.; RADM Oscar Gray, CO Nav Aerospace Med Center, Pensacola, Fla., and; CAPT James Acuff, CEC, USN, Naval Air Advanced Training Command.

Groundbreaking for the new Naval Dental Clinic at the Naval Station, Long Beach, Calif., occurred on 6 August 1971. The 20,000 square foot building will house 35 dental operating rooms, seven oral hygiene rooms, and complete prosthetic and dental repair facilities.



Participants in the groundbreaking for the new Dental Clinic in Long Beach included, from left to right: Dentalman V.G. White, Jr., USN; RADM M.G. Turner, DC, USN, Director Dental Activities, 11th Naval District, San Diego, Calif.; CAPT J.G. Chudzinski, Executive Officer, Naval Dental Clinic, Long Beach; CAPT A.L. McInturff, CO Naval Dental Clinic, Long Beach, and; Senior Chief Dental Technician A. Gochicoa, USN.



Artist's concept of new Naval Dental Clinic, Naval Base, Los Angeles, Long Beach, Calif. The building is now under construction.

RADM Oscar Gray, Jr., MC, USN, CO Naval Aerospace Medical Center, Pensacola, Fla., and CAPT Newton W. Allebach, MC, USN, Officer in Charge Naval Aerospace Medical Research Laboratory, presided at groundbreaking ceremonies for the new Non-ionizing Radiation Facility on May 6, 1971. The new construction will house most elaborate and modern microwave equipment, and a simulator of an extremely low frequency communication system. It will

serve to investigate biological effects of nonionizing radiation. Other participants in the event included: RADM John Thomas, USN, Chief of Naval Air Basic Training; CAPT Marvin D. Courtney, MC, USN, CO Naval Aerospace Medical Institute, parent activity of the Laboratory, and; CAPT Robert E. Mitchell, Head of the Medical Sciences Dept. of the Laboratory. Doctors Dietrich E. Beischer, Vernon Reno and James D. Grissett will be the scientific investigators.

Figuratively speaking.....

Limited assignment of specialized Navy Enlisted Classification codes within the Hospital Corps, and removal of personnel so assigned from any seavey/shorvey system will now retain highly trained hospital corpsmen in medical fields for which they are qualified. Navy Enlisted Classification code distribution will permit greater personnel stability, increased job satisfaction, a greater return for training funds expended and reduced training requirements. The following enlisted Hospital Corps technical specialties are included in the limited distribution technical specialty program: HM-8402, 8403, 8408, 8409, 8415, 8416, 8417, 8432, 8433, 8452, 8463, 8466, 8482, 8483, 8484, 8485, 8486, and 8498. All detailing is to be centralized, probably by 1 July 1972. Each medical officer should become familiar with the provisions of BUMEDINST 1040.1 "Group X Hospital Corpsmen Career Planning," particularly enclosures (1) and (2). The instruction permits individual selection of career skills through related or cross-training at the petty officer first class level.

Mrs. Dennis R. Adams snipped the ribbon which officially opened the new Navy Lodge at NNMC, Bethesda, Md. The first guest at the new Lodge, Mrs. Adams may now remain close at hand throughout hospitalization of her 2-year-old daughter, Amy, who recently underwent open heart surgery at the Naval Hospital, NNMC, Bethesda, Md. Although Navy Lodges are completed at six naval facilities or more, and construction is underway at other bases for more Navy Lodges, NNMC is the first BUMED-managed activity to operate such a complex, providing inexpensive temporary accommodations for families of patients at the Naval Hospital. For a modest \$8.00 per day, up to five persons can stay in one of the units. The 22 modern motel-style units provide attractive furnishings including television, refrigerators and kitchenettes.



Standing at Navy Lodge opening ceremony, from left to right, are: YN3 D. R. Adams, USN; Mrs. Dennis R. Adams; RADM F. P. Ballenger, MC, USN, CO, NNMC, Bethesda, Md., and; RADM Allen A. Bergner, USN, Assistant Chief of Naval Personnel for Education and Training.

The delightful Amy Adams is pictured on page 29.



Master Chief Hospital Corpsman Robert J. Swartout, USN.

The Navy has opened a drug rehabilitation center at Naval Air Station Miramar, Calif., where drug users will be received following treatment at designated naval hospitals.

Drug Amnesty programs are presently operating at NAS Miramar, Calif.; Pearl Harbor, Hawaii; and Nha Be, Vietnam. The Nha Be facility is housed aboard two barracks ships moored side-by-side at the logistic support base, approximately 10 miles southwest of Saigon. The treatment program usually lasts about 30 days and three essential phases of management are: detoxification and testing in security area, one to four days;

Master Chief Hospital Corpsman Robert J. Swartout is the new Master Chief Petty Officer of the Navy Medical Department. He was appointed by the Surgeon General to fill one of the 23 new billets recently established by the Chief of Naval Operations.

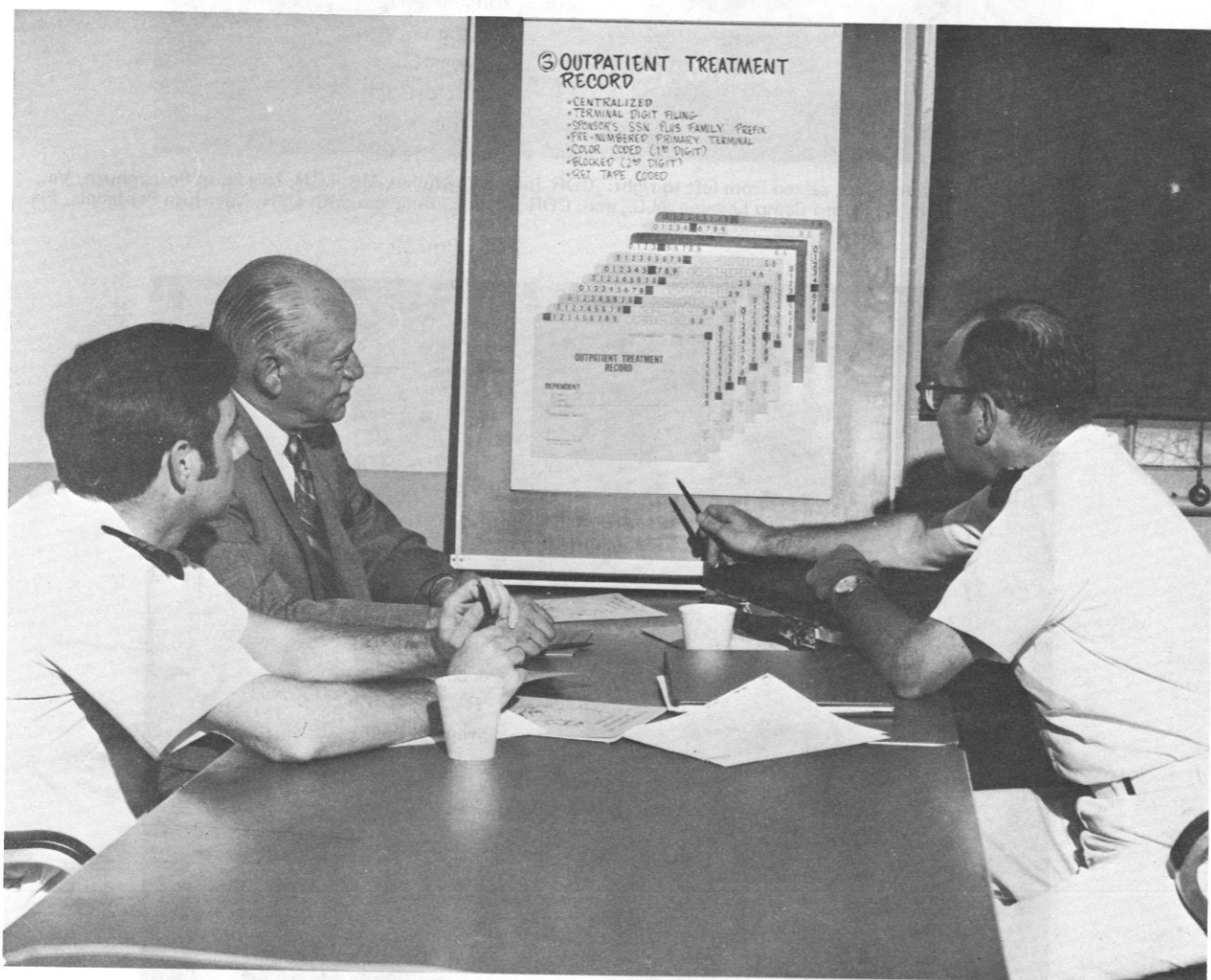
Master Chief Swartout, who is the senior E-9 in the Hospital Corps, brings to his new duties a wealth of experience gained through a diversified naval career. He has served at naval hospitals and dispensaries, on board ship and with the Marines, and at Naval District Headquarters; he is currently stationed at BUMED. He has had considerable experience in coordinating the training program for enlisted medical personnel and, prior to the recent centralization of personnel distribution, was responsible for the assignment of all senior and master chief hospital corpsmen in the Navy.

The Master Chief Petty Officer of the Medical Department will act as the central contact point for the senior enlisted advisors at the 86 major medical facilities under the command of the Surgeon General. Master Chief Swartout is looking forward to his new duties, designated Code 13A in BUMED. He firmly believes that the newly established line of communication between the Medical Department Headquarters and the medical facilities in the field, will do much to assist the Surgeon General in his efforts to provide high quality medical care to the Navy and Marine Corps family.

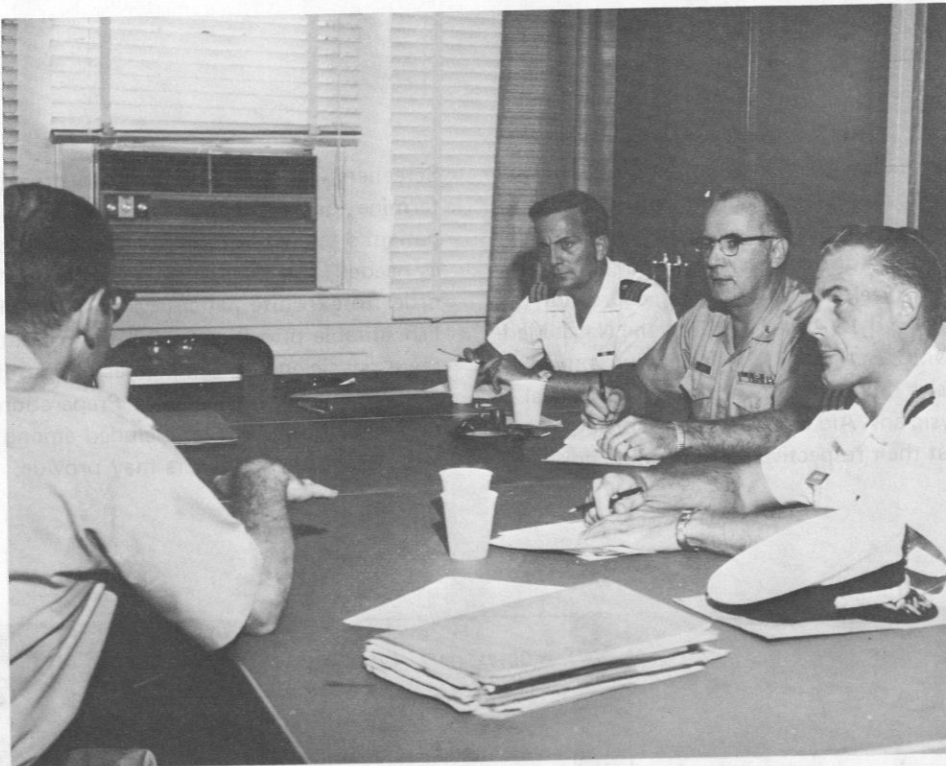
routine of work, sports, individual counseling and group therapy in another security area, and; optional third phase or half-way house where patients plan and supervise the routine that allows for off-base passes. Rehabilitation Program Director is LT Michael J. Sarg, Jr., MC, USN. LCDR Mario R. Schwabe, MC, USN, Chief of Psychiatry at Naval Hospital Camp Lejeune, N.C., is a consultant to the Drug Amnesty Center in Nha Be, RVN. It has been said that more than 95% of the patients have voluntarily reported for help before becoming physically addicted to the point of experiencing withdrawal symptomatology.

Until the 52-week course of instruction in the Physician's Assistant Preceptorship Program comes to fruition, the immediate or first level form of assistance is already underway in the form of the Physician's Aid (Screener) Program. The ten-week intensive training course for screeners commenced 16 August 1971 at the Naval Medical School, NNMC, Bethesda, Md. Following four weeks of intensive didactic study at the Naval Medical School, 20 Physicians' Aid Screeners will serve a six-week preceptorship at their respective parent commands. The

Screeners will take a brief history from patients to determine the chief complaint. They will determine the patient's temperature, pulse and blood pressure values as needed, and may order pertinent laboratory tests in order to expedite patient care. They will also establish suitable priorities among the patients waiting to see a physician. In some cases direct referral to a specialty clinic may be made. Preparation of prescription refill forms will be included among the list of services which the Screeners may provide.



Key figures in planning the Physician's Aid (Screener) Program at Naval Medical School, NNMC, Bethesda, Md., are shown, seated from left to right: CDR Joseph S. Cassells, MC, USN; Mr. Earl R. Shappell, Course Director, and; CAPT James Wilson, MC, USN.



CAPT Wilson (left) meets with preceptors, seated from left to right: CDR Joseph T. Mullen, MC, USN, Nav Hosp Portsmouth, Va.; CAPT Victor L. Stotka, MC, USN, Nav Hosp Camp Lejeune, N.C., and; CDR Elmer L. Bingham, MC, USN, Nav Hosp Pensacola, Fla.



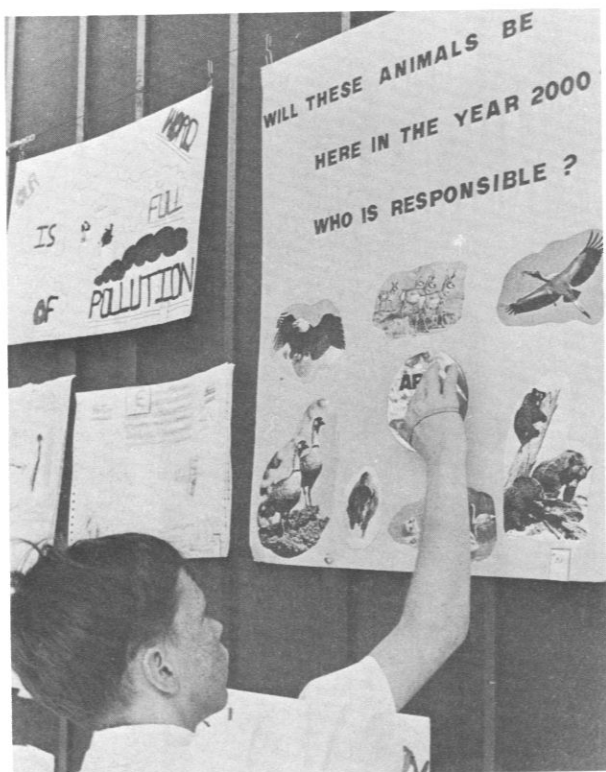
CDR Cassells (right) chats with Screeners HMC John P. Ables, USN (left) and HMC Jay Lockridge, USN (center).



CDR Jerome Levy, MC, USN of Nav Hosp San Diego, Calif., (right) and LCDR Steven T. Knee, MC, USN, (center), preceptor from Nav Hosp Oakland, Calif., are seen meeting with CAPT Wilson (left).



Screeners at work.



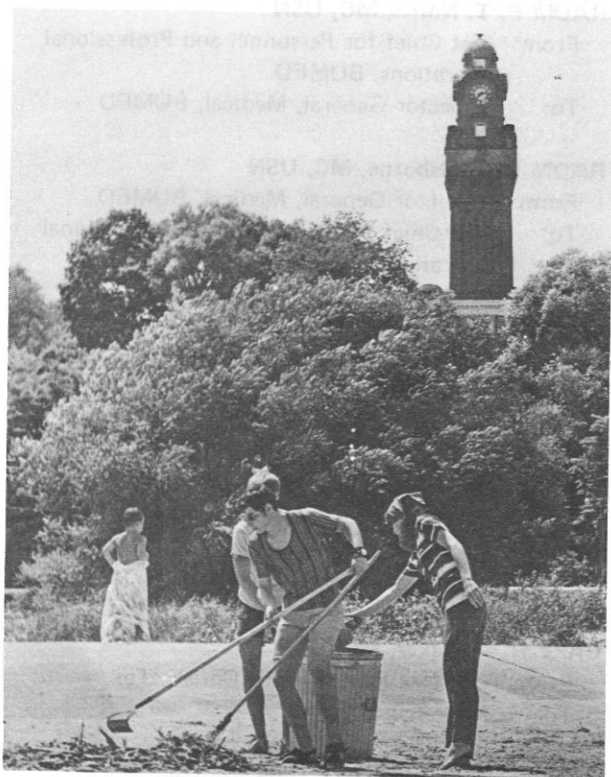
GLEAM-sponsored poster contest interested children in the program.

On 19 August 1971, volunteer workers within the Great Lakes Naval Base area dedicated a new Ecology Center. Congressman Robert McClory of the 12th Illinois Congressional District; RADM Draper L. Kauffman, USN, 9th Naval District Commandant and Commander Naval Base, and; RADM William C. Turville, CO Nav Hosp Great Lakes, Ill., participated in ribbon-cutting ceremonies dedicating the new headquarters of GLEAM (Great Lakes Ecology Association of Military). GLEAM concentrates on positive action for improvement of the environment, both at Great Lakes and in surrounding communities. The concept was initiated by CDR William N. Ahrens, XO Navy Public Works Center.

The George Washington University, Washington, D.C., now offers a program leading to the degree of Master of Science in Special Studies (Oral Biology) for courses conducted at the Naval Dental School, NNMC, Bethesda, Md. All officers enrolled in the Dental School's graduate courses in general dentistry and dental specialties, under this new program, are eligible for admission to degree candidacy. In this cooperative educational endeavor, instructors will be assigned from the University faculty and the Naval Dental School staff. The Master's Degree Program is another highlight in the Naval Dental School's history of academic association and advance.



GLEAM Headquarters, Ninth Naval District, Great Lakes Naval Base, Great Lakes, Ill.



GLEAM members help groom Nunn Beach.

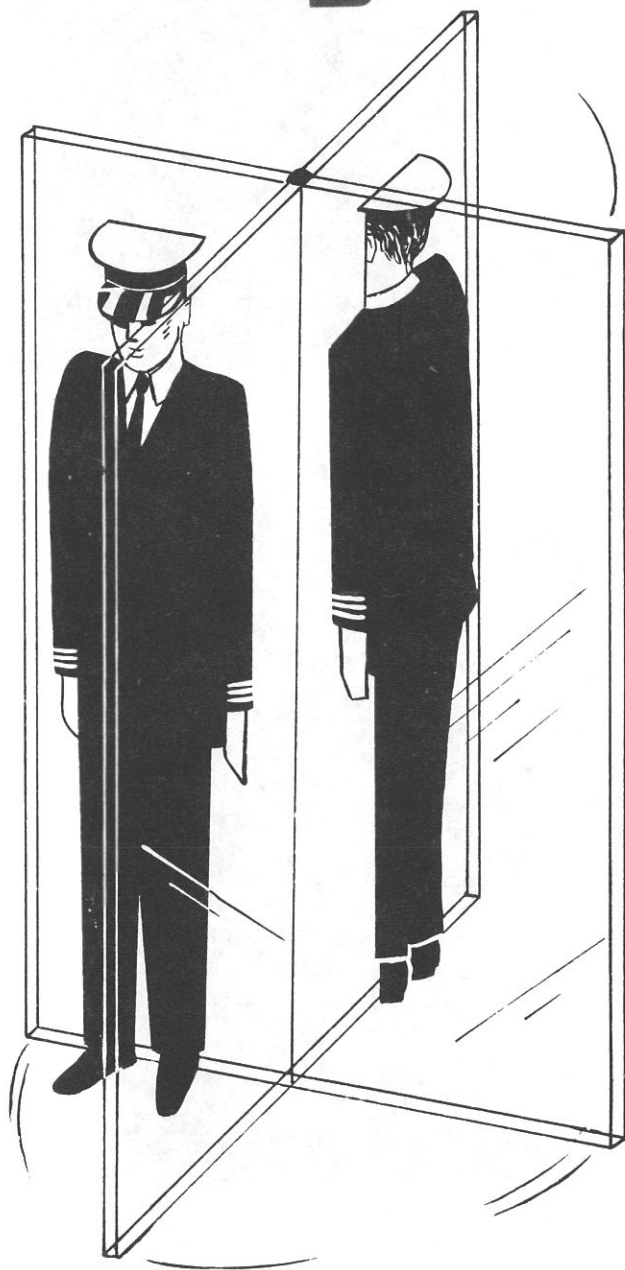


Great Lakes sailor works hard to clean debris from beach area.



CAPT W.C. Wohlfarth, Jr., DC, USN, CO Nav Dental School, NMMC, Bethesda, Md., signs agreement with the George Washington University, seated at the desk of Dr. E.R. Magruder, Dean of the College of General Studies. Onlookers stand behind, from left to right: RADM E.C. Raffetto, DC, USN, Assistant Chief for Dentistry, BUMED, and Chief of the Dental Division; RADM F.P. Ballenger, MC, USN, CO NMMC, Bethesda, Md.; Dr. W.F.E. Long, Associate Dean of the Graduate School of Arts and Sciences, and; Dean Magruder.

Coming and Going



RADM F. T. Norris, MC, USN

From: Asst Chief for Personnel and Professional Operations, BUMED
To: Inspector General, Medical, BUMED

RADM D. P. Osborne, MC, USN

From: Inspector General, Medical, BUMED
To: Asst Chief for Personnel and Professional Operations, BUMED

RADM J. L. Yon, MC, USN

To: Dir/CO Navy Regional Medical Center, Portsmouth, Va.
Addu: CO Nav Hosp Portsmouth, Va.

CAPT W. P. Arentzen, MC, USN (RADM Selectee)

From: CO, Nav Hosp Camp Lejeune, N. C.
To: Dep Dir, Navy Regional Medical Center, Portsmouth, Va.

CAPT H. A. Baker, MC, USN

From: CO, Nav Hosp Corpus Christi, Tex.
To: Retirement

CAPT B. B. Barnhill, MC, USN

From: CO, Nav Hosp Guam, M. I.
To: CO, Nav Hosp Corpus Christi, Tex.

CAPT D. P. Bernard, MC, USN

From: CO, Nav Hosp Port Hueneme, Calif.
To: CO, Nav Hosp Guam, M. I.

CAPT R. G. Brown, MC, USN

From: CO, Nav Hosp Bremerton, Wash.
To: DMO, COMTHIRTEEN

CAPT F. W. Burke, MC, USN

From: Asst Flt Med Officer, CINCPACFLT
To: CO, Nav Hosp Annapolis, Md.

CDR T. R. Byrd, MC, USN

From: Environmental and Preventive Medicine Unit No. 5, San Diego, Calif.
To: O-in-C, Environmental and Preventive Medicine Unit No. 5, San Diego, Calif.

CAPT E. C. Cowart, Jr., MC, USN

From: CO, Nav Hosp in USS SANCTUARY (AH-17)
To: CO, Nav Hosp Port Hueneme, Calif.

CAPT W. F. Hansen, MC, USN

From: CO, Nav Hosp Taipei, Taiwan
To: Nav Sta Mayport, Fla. (Continued on p. 45)

"THE HAWK" AND DRUG AWARENESS

*By PH1 James A. Davidson, USN; PAO, Detachment
WESTPAC, Box 88, FPO San Francisco 96651.*

According to National figures, 50 to 60 percent of the population of the United States between the ages of 17 and 25 years have used marijuana; 14 percent of this group will go on to something stronger. A good percentage of this age group are now members of the U.S. Navy and those joining are in this age bracket.

"That something stronger may be hashish, a richer and concentrated form of marijuana," explains Senior Chief Yeoman (YNCS) John Stemmerman, USN, criminal investigator for the legal department aboard the Seventh Fleet attack carrier, USS Kitty Hawk (CVA-63); "from this point, for this small percentage of people, it is but a short and deadly step to heroin."

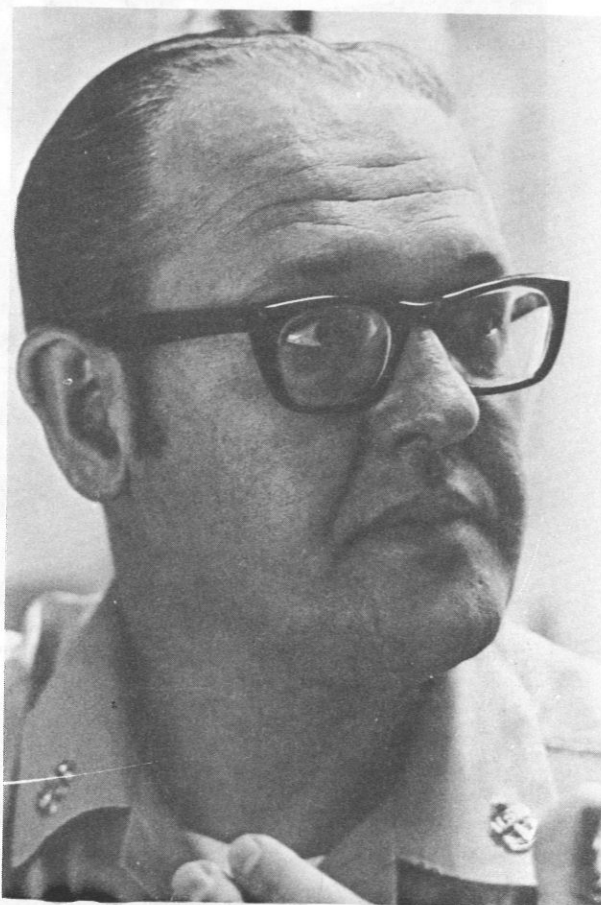
About 90 percent of YNCS Stemmerman's time is taken up with work related to the drug education program aboard the "HAWK." Most of this time is spent informing the crew what the drugs are and what they will do to a person's body. The presentation of drug information is dynamic and straightforward in delivery, a departure from the usual dry lecture.

According to YNCS Stemmerman, "education is the way to control the drug problem, not super harassment." And the program is being pursued that way. A roving team circulates in the Fleet "rapping" with officers and enlisted men, providing information on drug abuse.

"I show the people what the different drugs can look like, what they will do to you; those of you who will probably try them might as well know what you are doing and really do it up right," explains the bespectacled senior chief.

The Navy's involvement with drugs became evident to YNCS Stemmerman while he was stationed in Adak, Alaska. As chief in charge of the legal department, he encountered Navy personnel there who were picked up for possession of drugs. "I wanted to find out the real truth behind drugs; once I became involved, I found that I could help," YNCS Stemmerman states.

Working with a slide presentation and lecturing in a conversational manner, YNCS Stemmerman has spoken to more than 3,000 people; his largest audience has been 147, the smallest 11. The biggest problem, according to YNCS Stemmerman, has been to break down the barrier imposed by his khaki uniform and the career-man image. "Once I have broken down the barrier and gained the respect of the audience, they really start to open up. Then I can learn something from them — their attitude on drugs and information



A career Navyman, YNCS Stemmerman appreciates the problems created by drug addiction and he is helping to solve them through education.

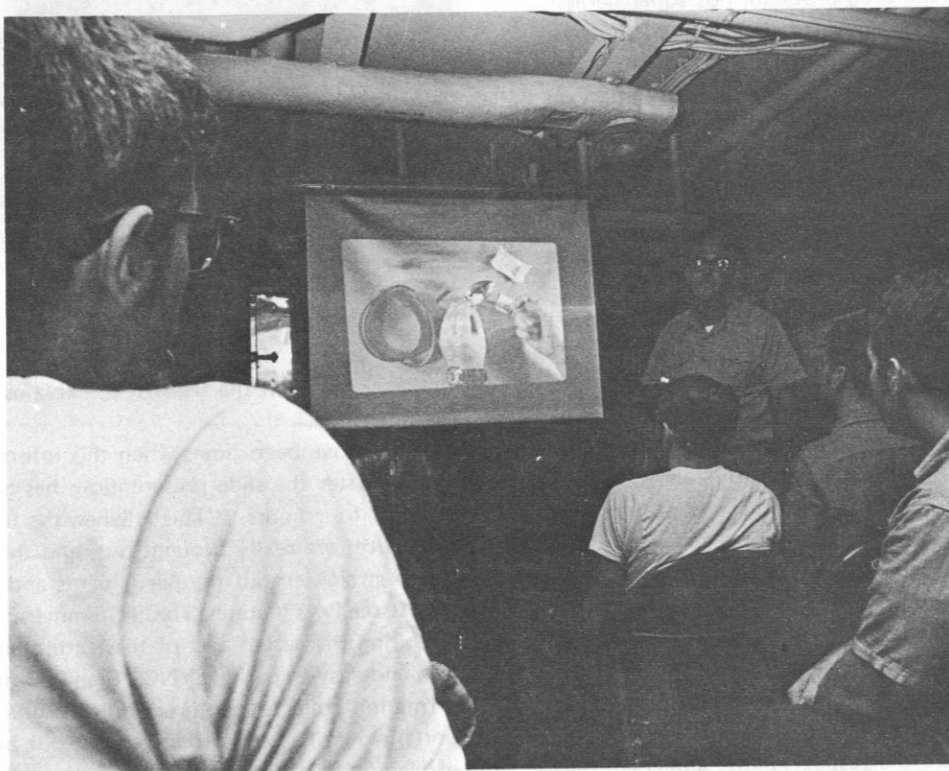
concerning personnel directly or indirectly involved in the drug scene on the 'HAWK'," explains YNCS Stemmerman.

There have been times when this informal "rap" session, after the slide presentation, has gone on for three or four hours. "This is when the untruths and half-truths are really brought out, and this is when I try to straighten out the participants and tell them the way it really is," states YNCS Stemmerman.

During the verbal part of the lecture and the question-and-answer period, YNCS Stemmerman utilizes information collected from periodicals, newspaper reports, magazines and brochures put out by the Bureau of Narcotics in Washington, D.C. In addition, YNCS Stemmerman has had some practical experiences with drug control.



YNCS Stemmerman (left) shows a young Navyman a kit of confiscated drugs and drug artifacts during a lecture aboard the "HAWK." The Chief pursues an open, honest approach to discussion on drugs.

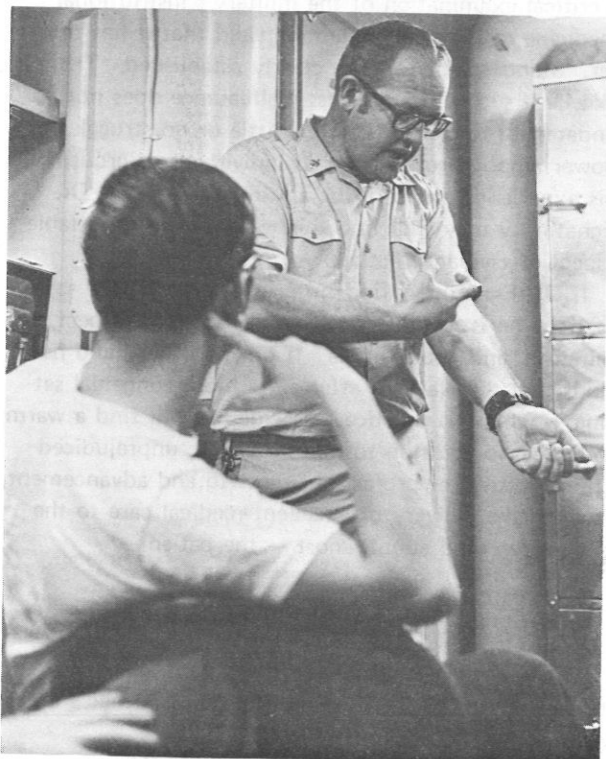


During one of his lectures aboard the KITTY HAWK, YNCS Stemmerman uses slides to describe the heroin addict's kit.

"I spent four months with the Narcotics Bureau of the San Diego Police Department. The first two weeks were concerned with keeping records, but after that I went into the streets, dressing the part of a person involved in the drug scene. This is where my education really started, and I learned first-hand what it was all about.

"There are three reasons why younger people get involved in the drug scene: curiosity generated by the publicity given to drugs; experimentation; and social acceptance of drugs by peer groups. Most people put the drug down the first time they try it, for in the case of marijuana which is often the first drug used, it is discovered to have a bad taste and it has to be used two or three times before a 'high' is obtained." The people who don't put marijuana down after the first experience may eventually end up on "smack." By then there is little hope of escape, for the body needs the substance to function, and becomes a slave to the drug.

It is important to understand that drugs from different areas of the world differ in potency and cost. This can be of major consequence to the sailor who travels extensively. In the Far East, a wide variety of drugs



YNCS Stemmerman explains to a lecture group aboard the USS Kitty Hawk that the heroin addict derives almost "sexual" pleasure when the drug-laden needle is plunged into his vein.



YNCS Stemmerman displays a confiscated homemade hashish pipe as an example of the efforts employed by addicts "to go soaring."

can be bought at rock-bottom prices and these drugs are high in potency. But not so in the United States. A sailor visiting Hong Kong can buy enough 85% pure heroin for \$1.50 to stay high for a day whereas the same amount in the U.S. would cost between \$25 and \$30 and would probably be only 10% pure.

All the areas in the Far East have a wide variety of drugs which are easily purchased, and at a nominal fee. The concentration and strength of drugs in the Far East is very high, which makes the problem of drugs there even more acute.

"The best area at the moment to obtain drugs is the Philippines, where both price and variety are excellent for anyone interested," explains the Chief with candor. "The Hong Kong area is second best, for a passive attitude toward drugs is present there. This means that you have to go out and look for the source yourself."

(Continued on p.45)



To the Editor: I read Dr. Egnatinsky's letter in the August issue with a surprising feeling of gratitude, a reaction which my fellow career officers may find more than a little paradoxical. On superficial reading, his letter may lead one to believe it says the writer is fed up with the Navy and can't wait to get out. On a closer look, Dr. Egnatinsky's letter turns out to be a plaintive cry from a dedicated physician, who properly places his patients' welfare above all else, and who is actually leaving safe harbor for unknown waters, because he thinks he will be able to give better care elsewhere. The world, and the Navy, need more doctors like him.

We in the Navy Medical Department need to study Dr. Egnatinsky's letter and take it to heart. Although the problems to which he alludes are not the rule by any means, we know that they exist and cry for solution. Patient care *does* come first, and when we forget it, we are not carrying out the mission with which we are entrusted. We need to look at ourselves with critical objectivity, and we must rediscover the dedication of a Dr. Egnatinsky. To his "Am I wrong . . .?" we must have the courage to say "No" and recognize that his question puts the finger on some serious weaknesses. And when he asks, "Am I alone . . .?" we must not only reassure him that we share his misgivings, but then we have to set about the business of reordering our thinking and reemphasizing our priorities. Our leaders need to get out from behind the shelter of their desks and *lead*. And those leaders must be recruited from the ranks of concerned clinicians whose primary concern is *patient care* and not self-glorification. A disheartening tendency toward leadership by committee and consensus has to be stopped, and the responsible *individuals* step forward to lead . . . doctors, with the strength of conviction to defend their decisions as they bear upon patient care, regardless of the popularity or unpopularity of those decisions among individuals whose primary concern is not the care of the sick. At the other end of the spectrum, we must find the means to impress upon our new doctors that their role is to

provide *patient care*, and that any benefit that may accrue to themselves is strictly secondary, although a proper concern of the Medical Department.

I wish Dr. Egnatinsky well. Many of us now in the Medical Corps are "retreads," having tried our hand at civilian practice at one time or other and having encountered the same kinds of problems in patient care as in the Navy, without some of the rewards and satisfactions. The civilian sector, at best, offers no less paperwork, no less competition for fund distribution, no less interpersonal conflict than the Navy.

In the light of what is in store for private medicine, a critical examination of the military's institutional medicine *does* reveal something valid that it has to offer. Standards of care are clearly established. There is excellent supervision. Gross malfeasance does not go undetected for long. There is little or no struggle for power among professionals as individuals or groups. (If his experience proves to be anything like mine, Dr. Egnatinsky may well find this the most insupportable aspect of civilian practice.)

If Dr. Egnatinsky finds in private practice the satisfactions he is seeking, I can only offer him respect, admiration, and good wishes. If on the other hand he finds that the Navy is, after all, a more congenial setting in which to practice medicine, he will find a warm welcome, in addition to uninterrupted, unprejudiced opportunities for professional growth and advancement, through the delivery of excellent medical care to the one person who counts most — the patient.

Norman Ronis
CAPT, MC, USN
Student Detachment
Industrial College of Armed Forces
Fort McNair
Washington, D.C. 20315

*The following letter was not addressed to the Editor.
The excerpt has been taken from official BUMED*

correspondence. The author's comments concerning two years of active naval service are of interest, and are reprinted here with his gracious consent.

"Not only did I find military medicine as practiced in the Naval Hospital, San Diego, California challenging and rewarding but additionally, it provided me with the first opportunity of following ambulatory patients over a two-year period. This opportunity had not been available at the Johns Hopkins Hospital nor at the Mayo Clinic. It greatly facilitated the transition from a residency training program into private practice. I was most impressed with the caliber of medicine as exemplified by Doctor Donald Kaufman and Doctor Donald M. Gragg. I found upon completion of my oral examinations in internal medicine in June of 1970 that the naval experience had strengthened rather than depleted my medical training. I can not praise too highly my experience in the service.

"In addition to my growing private practice I have recently been appointed Director of Medical Education

at the Hospital of the Good Samaritan in Los Angeles. My energies are thus directed not only to excellency in private practice but also to the development of a training program for physicians interested in internal medicine, taking into consideration the rapidly changing goals and philosophies in postgraduate medical education. My heart lies in both the care of private patients and the teaching of younger physicians. I am most fortunate to be involved with both at the present time.

"If I may be of any service to you either in recruitment of physicians for a career in military medicine from the Southern California area or by offering my time in teaching younger physicians interested in internal medicine at the various military hospitals in Southern California, I would be only too happy to do so."

William Brugh Joy, M.D.
Medical Office Building
1136 West Sixth Street
Los Angeles, Calif. 90017 ☞

(Continued from p. 40)

CAPT A.A. Helgerson, MC, USN

From: CO, Nav Disp Norfolk, Va.

To: Navy Regional Medical Center, Portsmouth, Va.

Addu: Base Medical Officer, NOB, Norfolk, Va.

CAPT L.P. Jahnke, MC, USN

From: Asst Chief for Aerospace Medicine, BUMED

To: Retirement

CAPT W.J. Kennedy, DC, USN

From: CO, 3rd Dental Company, 3rd MARDIV, FMFPAC

To: NAS Miramar, Calif.

CAPT R. Lawrence, Jr., MC, USN

From: CO, Nav Hosp Pensacola, Fla.

To: Naval Aerospace Medical Center, Pensacola, Fla.

CAPT R. M. Lehman, MC, USN

From: XO, Nav Hosp Camp Lejeune, N. C.

To: CO, Nav Hosp Taipei, Taiwan

CAPT W. T. Lineberry, Jr., MC, USN

From: Force Surgeon, NAVFOR and NAVADGRU MACV Saigon, Vietnam

To: CO, Nav Hosp Bremerton, Wash.

CAPT P. J. Sydow, DC, USN

From: MCB Camp Lejeune, N. C.

To: CO, 3rd Dental Company, 3rd MARDIV, FMFPAC ☞

(Continued from p. 43)

There is a Navy-operated school in San Diego which trains personnel to be drug abuse specialists. The course is 10-weeks long and graduated personnel are assigned to major staffs ashore and afloat, at recruit training commands, and other areas where mass numbers of personnel can be educated in the facts con-

cerning drug usage. YNCS Stemmerman hopes to report to the school once he leaves KITTY HAWK.

Experts in the area of drug abuse agree that the public must become aware of the drug problem, and should regard victims of drug abuse as ill persons who need education as well as medical care. The Navy understands this and is doing something about it. ☞



PREMIUM-PAID MORTGAGE INSURANCE FOR THE HOME-BUYING SERVICE FAMILY

DoD Information Guidance Series No. 8A-1, May 1971 (AFPS).

What assistance can members of the Armed Forces receive from the Federal Government and the Department of Defense when buying a house?

1. **Policy:** In August 1954, a new section was added to the National Housing Act, a law administered by the Federal Housing Administration (FHA) of the Department of Housing and Urban Development. The new provision, Section 222, was designed to assist in financing the purchase or construction of a home by a member of the Armed Forces on active duty through FHA-insured mortgages. By insuring the mortgage, the FHA program permits a member of the Armed Forces to obtain a home loan easier. The Department of Defense, or, in the case of a member of the Coast Guard, The Department of Transportation, pays the premium of the mortgage insurance, a payment which is normally made by a homeowner.

2. **Eligibility:** The opportunity to purchase a home under Section 222 is open to every member of the Armed Forces, regardless of rank. Individuals who apply must have completed two or more years of active duty in the Armed Forces or in the Coast Guard. In addition, an applicant must have (1) a good credit record, (2) sufficient income to meet the mortgage payments as well as household and family expenses, (3) sufficient cash to meet closing costs, and (4) a Certificate of Eligibility (DD Form 802). Application for the Certificate of Eligibility is made through a unit commander to the headquarters which maintains the applicant's personnel records.

3. **Procedures:** After a serviceman has been issued a Certificate of Eligibility, it is his responsibility to

locate and inspect houses in the price range and geographical area desired. Finding one, he then applies for a loan from any FHA-approved lender. When a lending agency accepts the serviceman's loan application, that agency will handle all the necessary arrangements with the FHA and will supervise the processing of the mortgage at the prevailing interest rate. Once a mortgage is insured, the interest rate remains that set forth in the mortgage endorsed by the FHA throughout its life. Any local FHA office can provide a serviceman with detailed reports on housing availability, price range, local economy, and other factors bearing on the housing situation in the area where he is contemplating purchasing a home.

4. **Conditions:** An FHA Section 222 mortgage can only be used to purchase a one-family dwelling which will be used by a serviceman as his personal home. The house must be located in the United States, Puerto Rico, Guam, Trust Territory of the Pacific Islands, or the Virgin Islands. Construction and design of the house must meet the FHA minimum property standards. A Section 222 loan *cannot* be used to refinance a home that is already owned by a member of the Armed Forces.

o-Maturity: Maximum maturity of an FHA-insured mortgage is 35 years or three-fourths of the FHA estimate of the remaining life of the property, whichever is the lesser time period. The majority of the loans insured under Section 222 are for 30 years. Recent FHA directives provide that a 35-year loan will not be granted if the borrower qualifies for a 30-year loan.

o-Amount: Top mortgage amount insurable by the FHA under Section 222 is \$33,000.* However, there is no limit on the price that a serviceman can pay for a home. A serviceman must *pay all cash for the excess* over the FHA maximum of \$33,000; there can be no secondary financing of the amount over \$33,000.

o-Downpayment: A certain downpayment must be made on a house purchased under Section 222, and this downpayment is in addition to the closing/settlement costs. Here are two examples of FHA-required downpayments on a house costing \$33,000:

If your house was built under an FHA preconstruction commitment, you pay:

Three (3) percent on the first \$15,000 . . .	\$ 450
Ten (10) percent of value between	
\$15 - 25,000	\$1,000
Fifteen (15) percent of value between	
\$25 - 33,000	\$1,200
TOTAL DOWNPAYMENT	\$2,650

If your house was not built under a preconstruction commitment and is less than one year old, you pay:

Ten (10) percent on the first \$25,000 . . .	\$2,500
Fifteen (15) percent of value between	
\$25 - 33,000	\$1,200
TOTAL DOWNPAYMENT	\$3,700

5. Owning A House: Before you make any move to sign for a house, make an appointment with your legal assistance office. The advice you will receive there is free and may save you money and trouble. However, the staff of the legal assistance cannot represent you in the actual negotiations and may recommend that you hire an attorney skilled in real estate law to represent you at the final sale.

o-Warranty: If you buy a new house you will be given a warranty by the builder. In it the builder certifies that the house has been constructed in conformity with the plans and specifications on which the FHA has based its valuation of your house. The warranty is effective for one year from the date you get title to your home or take possession.

Some of the items which are considered covered by the builder's warranty and which should be corrected without charge should defects appear are (1) general workmanship, (2) proper heating and cooling, (3) a roof free from leaks, (4) a dry basement, and (5) a proper, firm foundation. Where you find defects, notify the builder and give him a reasonable time to make corrections. If the builder fails to respond,

*In certain areas, FHA-insured mortgages may range as high as \$49,500. A local FHA office will have current information.

contact the FHA-insuring office *in writing* to request their assistance before the warranty period ends.

o-Record Keeping: As a homeowner you must keep a complete and accurate set of records, both for your own information and for use in claiming tax deductions. Pay all your expenses relating to the house by check and keep the cancelled checks with your records. As a homeowner, your real estate taxes and mortgage interest payments are so large that it will almost certainly be to your advantage to file your income tax return with itemized deductions rather than with the standard deductions.

Every capital improvement you make in the house, such as fixing up the basement into a den, or tiling a bathroom, will result in increased capital gain if you sell the house at a profit later. Once again, accurate records of expenses in these projects can result in tax relief when you sell the house.

Checklist When Buying Or Building A Home

Location

- Convenient to public transportation
- Stores and shopping centers nearby
- Schools are located in neighborhood
- Play areas are supervised and safe

Lot

- Lot appears to drain satisfactorily
- Lawn and plants are in good health
- Septic tank (if any) in good condition

Exterior

- House fits in well with other houses
- Screens/storm windows in good condition
- Paint, siding, brick presentable
- Evidence of dry rot/termites

Interior

- Rooms sufficient for growing family
- Kitchen/dining area sufficient
- Closet space in all bedrooms
- Full/half baths conveniently located
- Storage space adequate and dry

6. Selling The House: A serviceman on active duty is subject to transfer and may face the problem of selling a house on short notice. First step in selling is to request an up-dated version of the FHA home market report (see para. 3) in order to be fully informed on market prices. There are two recommended ways of arranging the financing:

o-The buyer can pay cash, or finance the purchase with a new mortgage which he obtains, and the serviceman can then pay off his outstanding mortgage

balance and end his obligation. The military man's *Service will pay the prepayment penalty of one percent* which is charged on all FHA loans that are paid off in advance of scheduled payment.

o-The buyer can make a downpayment of the difference between the selling price and the unpaid mortgage. *If the buyer is acceptable to the FHA*, and the lender releases the serviceman from liability, the lender can substitute the buyer's name on the mortgage. The FHA will then consent to the serviceman's release from liability. It is important to obtain release from liability, since the serviceman will not be eligible for another FHA-insured mortgage until release has been obtained.

Contact your legal assistance office for advice *before signing any papers* which concern the sale of a house.

References and Reading

DoD Directive 1338.4 "Mortgage Insurance For Servicemen to Aid in the Construction or Purchase of Homes," (Army Reg. 608.8/SecNav Inst. 1741.4B/AF Reg. 34-63).

"The Home Buying Serviceman," HUD-121-F. For a copy write to HUD (FHA), Washington, D.C. 20410.

USAF Judge Advocate General Law Review Vol. XI, No. 1, Winter 1969, "Advice on the purchase and sale of a home and lease of dwellings by military personnel." (Copies are available at legal assistance offices.)

CHAMPUS

(The Civilian Health And Medical Program of the Uniformed Services)

DETAILS ABORTION POLICY

Medical care for spontaneous abortions and their complications for CHAMPUS beneficiaries is payable on an inpatient basis regardless of where the abortion occurs.

Whether the miscarriage occurs in a doctor's office, patient's home, a taxi or elsewhere, the health care services will be subject to the inpatient cost-sharing provision under the Civilian Health and Medical Program of the Uniformed Services.

By law, a minimum \$25 charge is incurred by dependents of active duty personnel when they are hospitalized in civilian inpatient facilities. Inpatient care beyond fourteen days is charged for at the rate of \$1.75 a day.

Retired personnel and their dependents and the dependents of deceased active duty and retired personnel are, by law, responsible for 25 per cent of the charges for inpatient care with the government paying 75 per cent of the remaining allowable costs.

CHAMPUS officials state that persons who believe they may be entitled to compensation on previously submitted claims as the result of the foregoing clarification of policy may submit a request for readjudication of their claims by writing to the Fiscal Administrator of the State concerned.

OKAYS TAX PAYMENTS

State and local taxes which apply directly to health services and supplies that are CHAMPUS benefits are considered part of the beneficiary's medical expenses and are payable under the cost-sharing provisions of the Civilian Health and Medical Program of the Uniformed Services according to a recent CHAMPUS ruling.

CHAMPUS officials explained that such taxes — sales taxes, use taxes, professional, business or occupation taxes and gross income and gross revenue taxes — will be included as part of the reasonable charges determined by the fiscal administrator or hospital contractor for all authorized services, supplies and/or equipment furnished CHAMPUS beneficiaries.

This clarification applies to both the basic CHAMPUS program as well as to benefits under the Program for the Handicapped.

CHAMPUS officials state that persons who believe they may be entitled to compensation on previously submitted claims as the result of the foregoing clarification of policy may submit a request for readjudication of their claims by writing to the Executive Director, OCHAMPUS, Denver, Col. 80240.—Washington, D.C. (AFPS).

MO STAFF ASSIGNMENTS

In the July 1971 issue of U.S. NAVY MEDICINE a message from the Surgeon General defined and explained the management-administrative role of the Navy medical officer. In the summers of 1972 and 1973 a number of medical officer positions will be available that come under the category of "staff jobs." A list of these positions is provided here, and interested medical officers should express their desire for such an assignment to the appropriate office in BUMED.

1. Division Surgeon — SECOND Marine Division, Camp Lejeune, N.C.
2. Commanding Officer — SECOND Medical Battalion, Camp Lejeune, N.C.
3. Division Surgeon — THIRD Marine Division, Okinawa
4. Commanding Officer, THIRD Medical Battalion, Okinawa
5. Force Medical Officer, COMPHIBLANT, Norfolk, Va.
6. Headquarters, FMFLANT, Norfolk, Va.
7. Staff Medical Officer, COMCRUSDESLANT, Newport, R.I.
8. Marine Corps Recruit Depot, San Diego, Calif.
9. Staff, CINCLANTFLT, Norfolk, Va.
10. Office Naval Disability Evaluation, Washington, D.C.
11. Bureau of Medicine and Surgery
 - a. Professional Division
 - b. Physical Qualification Section
 - c. Plans and Operations
 - d. Occupational Medicine
 - e. Research
12. Deputy Surgeon — MACV-Saigon, RVN
13. Force Medical Officer — NAVFORV-Saigon, RVN
14. Staff COMSERVPAC, Honolulu, Hawaii
15. Force Medical Officer — COMCRUSDESPAC, San Diego, Calif.
16. CINCUSNAVEUR
17. Staff — SIXTH Fleet
 - SEVENTH Fleet
18. Headquarters, Marine Corps
19. Naval Support Activity, Antarctica
20. Navy Supply Center, Oakland, Calif.

Medical officers in the rank of CAPT or CDR should address their interest to BUMED, Code 317. At regular intervals similar lists for other positions will be presented in this publication, including those available in the rank of LCDR and LT.

In addition a description of the duties, responsibilities and other facets of each position will be

summarized at regular intervals in future issues of this magazine. Interested medical officers are invited to request a copy of any summary for their perusal.—Code 317, BUMED. 📄

TROPICAL MEDICINE COURSE

A short course in Tropical Medicine is given at the Gorgas Memorial Laboratory, Panama City, Panama, several times each year. The group number and inclusive dates for calendar year 1972 are as follows:

<i>Group Number</i>	<i>Inclusive Dates</i>
IX	14 Jan 1972 — 25 Feb 1972
X	7 Apr 1972 — 19 May 1972
XI	14 July 1972 — 25 Aug 1972
XII	29 Sept 1972 — 10 Nov 1972

Navy residents or fellows who are in their senior year level of training in Dermatology, Pathology, Pediatrics, and Internal Medicine and its related subspecialties are eligible for nomination and selection. Priority shall be given to those residents and fellows who are in programs which have established this course as either an integral or an elective/integral part of that training program. Command nominations for other Medical Corps officers will be considered after all graduate medical training requirements have been accommodated.

Nominations shall be submitted in accordance with BUMEDINST 1520.8C of 10 November 1970, BUMEDINST 4651.1 of 15 July 1970, or SECNAVINST 4651.15B of 3 July 1969, whichever is applicable. BUMED, Code 316 will arrange for area clearances and registration of those medical officers selected for attendance. Therefore, it is requested that the below information be furnished for each nominee at least 10 weeks prior to the convening date of the desired period of training.

- a. Name, Rank, Corps, Social Security Number, File Number, and Designator.
- b. Present status (e.g.: staff, resident, fellow or other).
- c. Specialty or subspecialty (e.g.: Internal Medicine, Hematology, or Pathology, etc.)
- d. Group Preference (specify Group IX, X, XI, or XII).
- e. Mailing address of nominee.
- f. Full name, relationship and address of NOK.—Code 316, BUMED. 📄

POSTGRADUATE SHORT COURSES FOR MEDICAL DEPARTMENT OFFICERS
SPONSORED BY THE DEPARTMENT OF THE ARMY DURING FISCAL YEAR 1972

The following postgraduate professional short courses will be conducted by the Army Medical Department during Fiscal Year 1972. The Bureau of Medicine and Surgery has been allocated a limited number of quotas for each course. Eligible Medical Department officers desiring to attend should submit their requests in accordance with applicable directives, in time to reach BUMED at least six weeks prior to the convening date of the course desired.

<i>COURSES</i>	<i>INSTALLATION</i>	<i>DATE</i>
Accident Pathology	Armed Forces Institute of Pathology (AFIP)	8 — 10 May 1972
Advanced Clinical Pathology of the Oral Regions	Army Institute of Dental Research, Walter Reed Army Medical Center (WRAMC)	7 — 11 Feb 1972
Aerospace Pathology	AFIP	22 — 24 Nov 1971
Application of Histochemistry to Pathology	AFIP	10 — 14 Jan 1972
AFIP Course in Oral Pathology (Annual)	AFIP	6 — 10 Mar 1972
AFIP Lectures (Annual)	AFIP	27 — 31 Mar 1972
Army Dietetic Internship Faculties Course	Brooke General Hospital, BAMC, Fort Sam Houston, Tex.	1 — 5 May 1972
Cardiovascular Pathology	AFIP	3 — 7 Apr 1972
Current Concepts of Restorative Dentistry	Army Institute of Dental Research, WRAMC, Wash., D.C.,	13 — 17 Sept 1971
	Letterman General Hospital, San Francisco, Calif.	6 — 10 Dec 1971
Current Problems and Trends in Medical Plans and Operations	Fitzsimons General Hospital Denver, Colo.	17 — 21 Apr 1972
Current Trends in AMSC Management	Walter Reed Army Institute of Research, WRAMC, Wash., D.C.	7 — 11 Feb 1972
Educational Technology for AMSC Officers	U.S. Army Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.	17 — 28 Apr 1972
Forensic Dentistry	AFIP	4 — 8 Oct 1971
Forensic Pathology	AFIP	15 — 19 Nov 1971
Introduction to Electron Microscopy	AFIP	29 Nov — 3 Dec 1971
James C. Kimbrough Urological Seminar	Letterman General Hospital San Francisco, Calif.	2 — 5 Nov 1971
Neuropathology	AFIP	31 Jan — 4 Feb 1972
Ophthalmic Pathology	AFIP	8 — 12 Nov 1971 28 Feb — 3 Mar 1972
Oral Diagnosis and Therapeutics	Army Institute of Dental Research, WRAMC, Wash., D.C.	17 — 21 Apr 1972

<i>COURSES</i>	<i>INSTALLATION</i>	<i>DATE</i>
Oral Surgery	Army Institute of Dental Research, WRAMC, Wash., D.C.;	10 — 14 Jan 1972
	Letterman General Hospital San Francisco, Calif.	25 — 29 Apr 1972
Orthopedic Pathology (for Pathologists)	AFIP	13 — 19 Feb 1972
Otolaryngology Basic Science Course	AFIP	10 Apr — 19 May 1972
Pathology of Laboratory Animals	AFIP	20 — 24 Sept 1971
Pathology of Radiation Injury	AFIP	13 — 17 Sept 1971
Pathology of the Aquatic Environment	AFIP	19 — 21 Apr 1972
Perceptual Motor Dysfunction for Occupational Therapists	Walson Army Hospital Fort Dix, N.J.	10 — 14 Apr 1972
Periodontics	Letterman General Hospital San Francisco, Calif.;	28 Feb — 3 Mar 1972
	Army Institute of Dental Research, WRAMC, Wash., D.C.	13 — 17 Mar 1972
Plastic Surgery in the Military Services — Problems, Reviews, New Developments	Walter Reed General Hospital WRAMC, Wash., D.C.	25 — 27 Jan 1972
Present Concepts in Internal Medicine	Letterman General Hospital San Francisco, Calif.	27 — 30 Oct 1971
Preventive Dentistry	Army Institute of Dental Research, WRAMC, Wash., D.C.	18 — 22 Oct 1971
Prosthodontics	Letterman General Hospital San Francisco, Calif.;	27 Sept — 1 Oct 1971
	Army Institute of Dental Research, WRAMC, Wash., D.C.	15 — 19 Nov 1971
Seminar in Anatomy and Physiology	U.S. Army Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.	1 — 12 May 1972
		15 — 26 May 1972
Social and Preventive Psychiatry	Office of the Surgeon General, DA, Forrestal Building, Wash., D.C.	7 — 11 Feb 1972
Surgical and Orthopedic Aspects of Trauma	Brooke General Hospital, BAMC, Fort Sam Houston, Tex.	6 — 10 Mar 1972
Symposium on Pulmonary Diseases (Annual)	Fitzsimons General Hospital Denver, Colo.	13 — 17 Sept 1971
Gary P. Wratten Surgical Symposium	Walter Reed General Hospital WRAMC, Wash., D.C.	22 — 24 Mar 1972

This listing was provided by Code 316, BUMED. Further correspondence and requests should be directed to Code 316. ☛

SEMINARS ON LEPROSY

The below listed two-day and three-day seminars for 1971-72, have been scheduled by the Department of Health, Education, and Welfare, Public Health Service at the U.S. Public Health Service Hospital, Carville, La. 70721.

Interested Medical Corps officers who desire Government sponsorship may submit their requests in accordance with SECNAVINST 4651.15B of 3 July 1969 or BUMEDINST 4651.1 of 15 July 1970, whichever is applicable. Enrollment arrangements for these courses are made by BUMED (Code 316).

Leprosy - Dermatological Aspects (Senior Residents in Dermatology)

5 - 7 October	1971
19 - 21 October	1971
2 - 4 November	1971
11 - 13 January	1972
7 - 9 March	1972
16 - 18 May	1972

Leprosy - Pathological Aspects 19 - 21 January 1972

Leprosy - Neurological Aspects 9 - 10 February 1972

Leprosy - Ophthalmological Aspects 29 - 30 March 1972

There are no registration fees or other costs assessed for any of these seminars. Lodging and meals for those attending will be provided on the Station. Commissioned officers who are receiving per diem will be charged the standard rate of \$1.50 per meal.

Transportation to and from the originating point to the New Orleans International Airport is the responsibility of those attending the seminar. The hospital will furnish transportation between the New Orleans International Airport and Carville, a distance of 67 miles.

Further information can be obtained from: Chief, Training Branch, U.S. Public Health Service Hospital, Carville, La. 70721.—Code 316, BUMED.

PROPARACAINE FOR TONOMETRY

For many years it was generally accepted that the topical anesthetic for routine eye procedures was tetracaine or pontocaine ophthalmic solution. More recently, ophthalmologists have substituted proparacaine hydrochloride ophthalmic solution as their item of choice. Not infrequently tetracaine or pontocaine ophthalmic solution causes moderate to severe adverse reactions. Both the frequency and severity of adverse

reactions are reduced by using proparacaine.

The Manual of the Medical Department, paragraph 15-92 (3) (a) still directs the use of tetracaine or pontocaine for tonometry, but is being revised to recommend the use of proparacaine hydrochloride. Pending official promulgation of this change, proparacaine hydrochloride should be used for tonometry as the drug of choice.

CONTINUATION PAY

On 5 October 1971 approximately 500 Medical Corps officers will be considered by a Medical Officers Continuation Pay Selection Board which will be convened to designate qualified Medical Corps officers eligible to receive continuation pay. After final approval of the Board's report, each officer selected will be notified by individual letter indicating the critical medical specialty category(ies) in which designated and the date eligible for continuation pay. The Board considers all those who are qualified or will be qualified within a 12-month period; therefore, the eligibility dates will vary with each selectee.

A Statement of Intent will accompany the letter of notification. This Statement *is not binding* but should be *promptly returned* to BUMED. It is used for budgetary information and planning purposes. Also upon receipt of a *positive* Statement of Intent, BUMED will forward to the officer the continuation pay forms prior to his eligibility date. If an active duty service obligation has been previously incurred for residency or other training under the provisions of BUMEDINST 1520.10E the officer will also receive a Service Extension Agreement which must be executed to participate in this program. This agreement is to extend the active duty service obligation previously incurred by one year. There is no requirement to extend active duty service obligation for future annual renewal contracts, except for those that may acquire an obligation subsequent to the initial acceptance of continuation pay.

Concerned officers are urged to review SECNAVINST 7220.61 series. For further information contact LCDR N. E. Denison, MSC, USN; telephone Autovon 29-44166.—Code 3173, BUMED.

RHABDOMYOLYSIS

The myoglobinuria which occurs in individuals, especially in recruits, following extreme muscular activity is not rare. Mild "exercise myoglobinuria" may be undetected, since the symptoms of muscle pain, slight swelling and stiffness may be mistaken for muscle

"strain" or "sprain" and brief passage of dark urine may not be observed. More severe cases are characterized by passage of dark red urine and markedly painful and swollen muscles. The latter most often come to the attention of the medical department and are frequently misdiagnosed as acute glomerulonephritis. Exertional myoglobinuria or rhabdomyolysis usually follows prolonged repetitive exercise of large muscle groups in unconditioned subjects by forced calisthenics such as pushups or squat jumps. The acute myoglobinuria usually clears in 48 to 72 hours and must be specifically identified during that period for a definitive diagnosis. A simple screening test is based on the differential solubility of myoglobin and hemoglobin. Confirmation by laboratory methods such as spectometry or electrophoresis is required. The development of oliguria or anuria at any time during the clinical course is a serious complication requiring prompt effective treatment. In severe cases where renal damage

or other residuals are sustained, referral to a physical evaluation board is in order; however, the majority of individuals may be considered for early return to full duty. In the latter group a gradually-increased exercise program must be stressed.

Medical department personnel, especially those attached to or near training facilities, should be thoroughly familiar with symptoms and causes of exertional myoglobinuria. Further, such personnel should advise training cadres in the establishment of a graduated physical training program and avoidance of prolonged exercises which cause severe repetitive stress of the same muscle group in unconditioned individuals. Finally, it must be emphasized that personnel who have exertional myoglobinuria (rhabdomyolysis) must be observed closely for signs of deterioration of renal function and that supportive measures must be promptly instituted if renal insufficiency supervenes.—Code 33, BUMED. 8

INTERMITTENT COMPRESSION UNIT ARM BOARD



Postoperative radical mastectomy lymphedema often necessitates application of intermittent compression to the involved arm. An elevated position of the arm during application is desired, and can be accomplished by placing pillows under the arm. This procedure can be cumbersome.

In the Physical Therapy Department, Naval Hospital Long Beach, Calif., an arm board is used. The arm board is safe (the Jobst sleeve can be held to the board with a velcro strap), easy to apply and adjustable to

various angles: 30°, 40°, 50°, and 60°. The flaps on the front of the board fit around the pad on the treatment table, and the back of the board can rest on the top of a chair. (See Figure 1)

Construction of the board requires 3/8" plywood, 1/2" x 1/2" wooden cleats, and two sets of hinges 8" long. Actual dimensions and diagram are available on request from this department.—LTJG Michael Skurja Jr., MSC, USNR; Nav Hosp Long Beach, Calif. 8



HARASSMENT PROTECTION

The Federal Trade Commission has recently been considering new laws to aid in consumer protection and credit reporting. Unfortunately, recent surveys have shown that debtor harassment is still prevalent among many collection agencies.

A typical case would include the receipt of a flood of pressing notices from a collection agency written on stationery which appears to be that of a government-controlled organization. These letters threaten legal action and damage to a debtor's credit rating. All too often debtors are also subjected to repeated phone calls at all hours of the day and night, both at home and on the job.

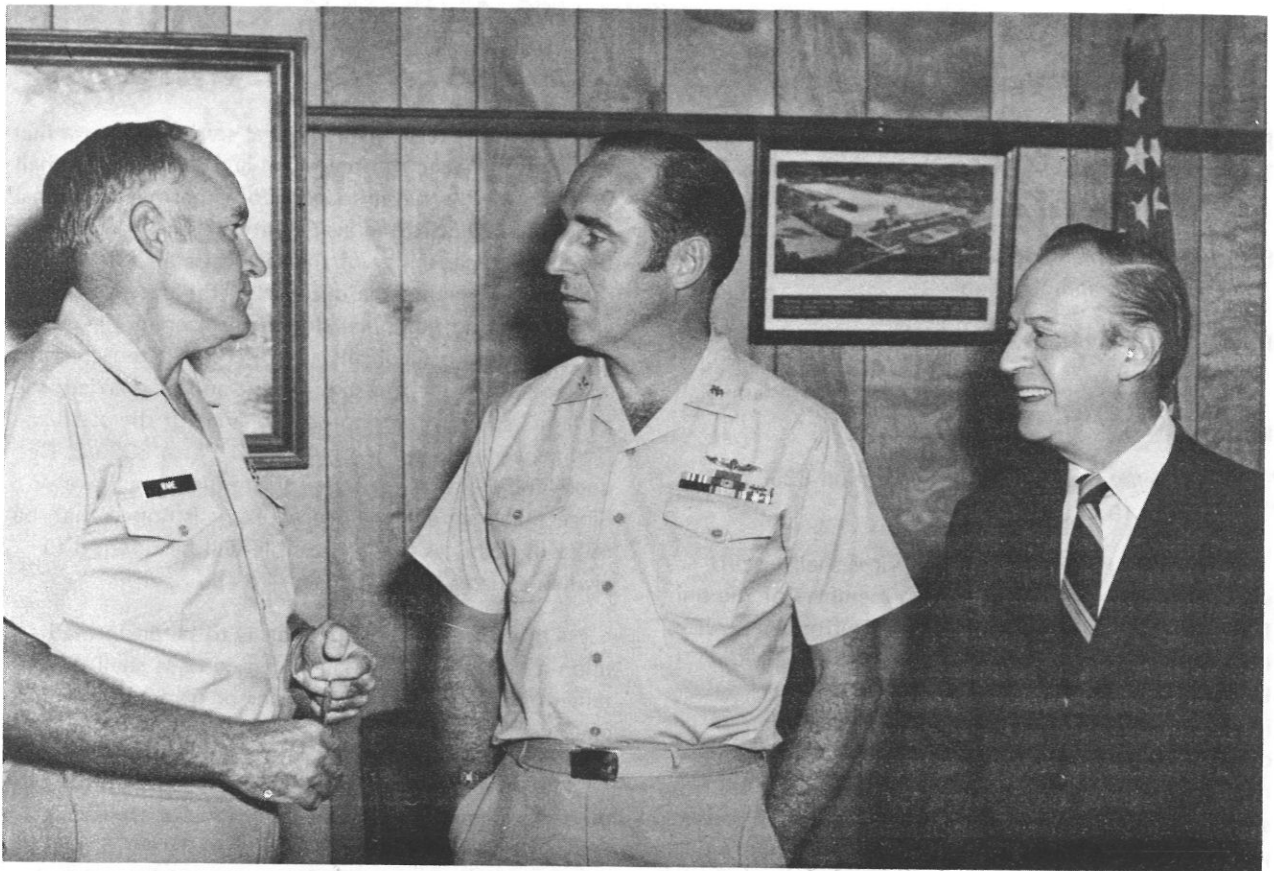
Persons should be aware that many times the individual calling will falsely represent himself to be a lawyer, policeman or private detective. Sometimes these calls are even made to neighbors, relatives and employers. In the event you are subjected to any of this type harassment, you should immediately contact the base legal office.

All too often legal officers hear the statement, "I'm afraid I'll lose my stripes if I do not pay this bill." Nothing could be further from the truth. The burden is on the creditor to show that a lawful debt exists. In the event a military member has been subjected to fraud or has received inferior merchandise, these could serve as the basis for denying liability.

The person to talk to, naturally, is a lawyer to aid you in making this determination. Of course, the failure to pay a lawful debt could make one subject to action under the Uniform Code of Military Justice.

One of the best ways to insure against this type of bother is to personally get to know the creditors with whom you deal. Whether you shop for your money at a credit union, bank or savings and loan, be sure you know and can trust the people with whom you deal. (AFPS Editorial by Capt. John B. Holden Jr., George AFB, Calif. Legal Office) ☸

CAPT J. H. Stover, Jr., MC, USN (BUMED Code 49) is searching for original copies of two outdated Marine Corps manuals; LFM-16 Medical Service 1952, and LFM-16 Medical and Dental Service 1958. Dr. Stover may be contacted by calling BUMED, AUTOVON 294-4246. Would appreciate your help. ☸



CAPT Dermot Murray, MC, USN, Director Planning Division, BUMED, (center) and Mr. David Southey (right) discuss Pensacola area medical facilities with CAPT Robert M. Ware, MSC, USN, (left), AO Naval Aerospace Medical Center, Pensacola, Fla. The BUMED officials, responsible for facilities planning, visited Pensacola in August while engaged in aerial and ground tours of naval activities and military/civilian medical facilities in the area of Meridian, Miss.—PAO, Naval Aerospace Medical Center, Pensacola, Fla. 🇺🇸

AMPHIBIOUS SHIPS SAVE \$17 MILLION MOVING MARINES

LONG BEACH, Calif. (NAVNEWS) . . . The recent arrival here of the attack cargo ship USS ST. LOUIS (LKA-116) brought to an end the Pacific Fleet Amphibious Force's operation to move the U.S. Marines and their equipment from Vietnam back to their home bases.

Dubbed "Operation Keystone," this method of redeployment saved \$17,000,000 in transportation costs, according to Marine Corps officials. The savings came about by using the Navy's amphibious ships rather than chartered or commercial means.

During the six segments of Operation Keystone, the Pacific Amphibious Force ships transported nearly 30,000 Marines back to their bases in Okinawa, Japan, Hawaii, and the continental U.S. They also transported more than 13,000 vehicles and seven million cubic feet of Marine Corps cargo.

The entire operation took more than two years, beginning on June 15, 1969 when the tank landing ship USS IREDELL COUNTY took on the first load.

There were 59 Amphibious Force ships involved in the operation and they made 139 trips to move all the Marines and their equipment. 🇺🇸

OFFICIAL INSTRUCTIONS AND DIRECTIVES

SECNAV INSTRUCTION 6300.2A

From: Secretary of the Navy
To: All Ships and Stations (less Marine Corps field addressees not having Navy personnel attached)
Subj: Family planning services; contraception, sterilization, and abortion
Ref: (a) SECNAVINST 6320.8D

1. *Purpose.* To promulgate guidelines for family planning services at Navy medical facilities.

* 2. *Cancellation.* SECNAV Instruction 6300.2 of 4 September 1970.

3. *Policy.* Family planning services shall be provided in Navy medical facilities to members of the uniformed services, beneficiaries of the Uniformed Services Health Benefits Program (ref. (a)), and, outside the United States, to other persons eligible for medical care in Navy medical facilities. All services shall be rendered in conformity with the principles of accepted medical practice, and subject to the availability of space, facilities, and capability of the staff. "Family planning services" may include (1) the prescription and provision of pharmaceutical preparations, including oral hormonal contraceptives, and mechanical devices, (2) surgical sterilization, (3) abortion, and (4) counseling. Physicians and other medical personnel who consider the performance of such procedures morally or ethically wrong shall not be required to perform them. Where space and facilities are not available or the capability does not exist for performance of sterilization or abortion procedures at local medical facilities, the hospital shall arrange for transfer to another uniformed service medical facility or procurement of such services in a local civilian hospital, with a staff possessing the capability and willingness to so perform. In the case of an active-duty member receiving treatment in a civilian hospital, the cost thereof shall be paid from funds of the sending naval hospital. Eligible dependents under such circumstances shall be issued certificates of non-*availability so they may have the procedure performed *under CHAMPUS. Outside the United States major *Navy overseas commanders shall determine on a country-by-country basis policies with respect to pregnancy terminations and surgical sterilization procedures, based on such considerations as pertinent mores, the applicable laws of the nations concerned, and applicable status of forces agreements. BUMED Code 39 should be kept advised of policy decisions reached.

4. Sterilizations

a. The decision for surgical sterilization is a matter solely between the physician and patient, and shall be performed in naval hospitals or other naval medical facilities subject to the availability of space and facilities and the capability of the medical staff. This procedure shall require the decision of the operating surgeon only, and no concurring medical opinions are necessary unless medically indicated. Written consent shall be obtained from the patient and, if married, the patient's spouse, prior to performance of the sterilization procedure, utilizing NAVMED Form 6300/2, Request and Consent for Surgical Sterilization, therefor. Since this is an elective procedure, it is hoped that, because of costs, as few as possible will be referred to civilian sources.

b. Where the sterilization is to be performed upon a dependent minor, written consent shall be obtained from the patient's sponsor or parents, or legal guardian.

c. Male sterilizations shall be performed only by physicians competent in the technique of transscrotal vasectomy. Female sterilization shall be performed or supervised only by a competent obstetrician-gynecologist.

5. Abortions

a. Abortions may be performed when medically indicated or for reasons involving mental health subject to the availability of space and facilities and the capabilities of the medical staff.

b. Performance of this procedure shall take place only in a naval hospital or medical facility having adequate operating room capabilities.

c. The concurrence of one additional qualified physician shall be obtained prior to the performance of an abortion procedure, and evidenced by completion of NAVMED Form 6300/3, Statement of Need for Therapeutic Abortion.

d. Written consent of the patient and spouse, if applicable, shall be obtained prior to the performance of abortion procedures, utilizing NAVMED Form 6300/4, Consent Form for Therapeutic Abortion, therefor.

e. In the case of minor dependent patients, written consent of the sponsor or parents or legal

guardian is required prior to performance of an abortion procedure.

f. Abortions shall be performed or supervised only by a competent obstetrician-gynecologist.

* g. Within the United States, whenever the State criteria on termination of pregnancies are more restrictive than the above, procedures in naval medical facilities in those States shall be in accordance with the more restrictive criteria.

6. *Travel Expenses.* Except as otherwise provided by law or regulation, transportation expenses for eligible dependents are not authorized.

7. *Supplies.* Oral contraceptive tablets, vaginal diaphragms, and intrauterine devices are available in the Defense Supply System. Other clinically acceptable contraceptive items such as foams, jellies, and creams are presently available only on the open market and are to be procured locally. When they are standardized, their availability will be announced in the BUMED Materiel Bulletin. Prescribed intrauterine contraceptive devices (IUD) shall be inserted only by obstetrician-gynecologists.

8. *Availability of NAVMED 6300/2, NAVMED 6300/3, and NAVMED 6300/4.* Supplies of NAVMED Forms 6300/2, NAVMED 6300/3, and NAVMED 6300/4 will be available from appropriate cognizant "I" forms and publications supply points.

FM CNO (Z-84) TO NAVOP

1. Our office fitness reporting system encourages discussion of performance evaluation between the reporting senior and the officer reported upon. In the case of junior officers the report must be shown, and performance and career assessment must be provided. Copies of the reports must be supplied upon detachment. These arrangements permit officers to judge and improve career performance.

2. For many years, we have encouraged naval officers to review their service records in BUPERS whenever they are in Washington in order to help assess their overall performance and set realistic personal and professional goals. Many lack adequate opportunity to do this, and recent recommendations and surveys have indicated that alternate means are needed. To answer this need a copy service will be established.

3. An officer may upon his individual request obtain a copy of the five most recent fitness reports in his service record. Because public law requires that such services be self-supporting, a handling charge of \$1.50 will be required. Written requests, accompanied

by personal check or money order for \$1.50 payable to Bureau of Naval Personnel may be made direct to BUPERS (Attn: Pers-E24). Requests will be filled on a first-in first-out basis.

FM CNO (Z-87) TO NAVOP (summarized)

Subj: Navy Uniform

Z-87 announces the following uniform changes:

A. *Officers:* Delete service dress khaki uniform, retaining tropical khaki long with worsted trousers and tropical whites. A summer weight service dress blue uniform is authorized.

B. *CPOs:* Delete service dress khaki and service dress white uniforms. Same provisions for tropical khaki long, tropical whites, and summer weight service dress blue uniform apply as for officers.

C. *Other Enlisted:* Delete present service dress blue uniform, undress blues and undress whites. Add two officer/CPO type service dress blue uniforms (one winter and one summer weight), white shirts, black tie and officer/CPO type cap with distinctive insignia. Tropical white uniforms are retained.

It is presently planned to retain the service dress khaki as an authorized uniform until 1 July 1975 with phase-in of summer weight service dress blue uniform to coincide with enlisted schedule. This uniform change reflects the desire for change on the part of a large majority of officers and enlisted men. It will bring the Navy into line with its sister services by providing one uniform from seaman to admiral.

FM CNO TO NAVOP (88)

*Subj: Eligibility to the BS/BA Program
at the Naval Postgraduate School*

Ref: BUPERSMAN 6630100

1. To increase the educational opportunities for all naval personnel commensurate with navy needs and individual ability and motivation, the BS/BA Program at the Naval Postgraduate School has been expanded to include commissioned warrant, limited duty, restricted line and staff corps officers.

2. Interested commissioned warrant, limited duty, restricted line and staff corps officers who meet the eligibility criteria outlined in reference (a) are encouraged to apply in accordance with reference (a) and to indicate a preference for the undergraduate curriculum, No. 461, on their Officer Preference Card, NAVPERS 1301/1.

3. A forthcoming change to the BUPERS Manual will reflect the above.

MANUAL OF THE MEDICAL DEPARTMENT

Change 65, 7 May 1971

- a. Adds articles concerning Dental Health Questionnaire and Navy Periodontal Screening Examination.
- b. Updates and combines 15-50 and 15-51 for the evaluation of a member's physical fitness for transfer.
- c. New form number (NAVMED 6150/7 vice 1345) for the Health Record Receipt, File Chargeout and Disposition Record.
- d. Updates chapter 23, sections I and II, on reports and forms.

Change 66, 25 May 1971

- a. Adds article 6-100 (3) on panoramic radiographic dental evaluation of recruits.
- b. Updates chapter 13, Section III, Naval Submarine Medical Center.
- c. Revises chapter 15, Section I, Physical Standards.
- d. Changes 15-58A, Members on Temporary Disability Retired List.

Change 67, 7 June 1971

Revises article 15-45 to eliminate the annual physical examination requirement for most categories of active-duty officers during the early years of their careers. As revised, the article requires triennial examination for non-flying officers between the ages of 24 and 36 years. Annual examinations will be required after 36 years of age. Certain other officers will still be required to undergo an annual examination (flag and general officers, aviators, divers, etc.). The requirement that all officers complete a history questionnaire which will be used by the examining physician in evaluating the officer's physical fitness and in the conduct of the examination was added. Certain other changes in the scope of the examination were also incorporated. All Navy Medical Department personnel should become thoroughly familiar with the new examination requirements, report preparation and reporting and inaugurate the new officer examination procedures immediately. NAVMED 6120/2 (Rev 6-71) "Officer Physical Examination Questionnaire" has been introduced into the forms publication segment of the Defense Supply System and should be requested in accordance with current directives, citing stock number 0105-208-3070.

BUMED NOTICE 6120 OF 4 JUN 1971

Subj: Annual Physical Checkup for Enlisted Female Members of the Navy and Marine Corps
Ref: (a) MANMED Art. 15-45A

Emphasizes the importance of a physical examination at 12-month intervals for all enlisted female

members of the Navy and Marine Corps.

Addressees (shore stations in the U.S. including Hawaii and Alaska) are requested to establish a program whereby all enlisted female members are periodically encouraged to request an annual physical examination in accordance with reference (a).

BUMED NOTICE 6320 OF 17 JUN 1971

Subj: NAVMED 6320/9, Dependent Eligibility for Medical Care
Ref: (a) SECNAVINST 6320.8 series

A survey has indicated a diversity of local forms used to certify eligibility for medical care for dependents who do not have a valid DD Form 1173 (Uniformed Services Identification and Privilege Card) in their possession. Reference (a) permits written certification of eligibility. Navy wide usage of such forms is sufficiently high to warrant a standardized NAVMED form. The new form, NAVMED 6320/9, shall be used to certify the medical care eligibility of dependents who do not have a valid DD Form 1173 in their possession but have previously been issued one. Local forms shall no longer be used. NAVMED 6320/9 is available from Cog I stock points of the Navy Supply System.

BUMEDINST 6710.50B OF 19 MAY 1971

Subj: Medical Material Program for Defense Against Biological and Chemical Warfare Agents
Ref: (a) OPNAVINST 04080.23 (NOTAL)
(b) NAVMED P-5041
(c) BUMEDINST 3440.5 (NOTAL)

Promulgates BUMED policy and instructions for Navy participation in the DoD Medical Material Program Against Biological and Chemical Warfare Agents in accordance with reference (a).

BUMED, through the authority of reference (a), funded and prepositioned some medical items for defense against biological and chemical warfare attacks by providing material to minimize casualties resulting from such attacks. This program consisted of prepositioning a broad spectrum antibiotic, an atropine salt, and Pralidoxime Chloride (2 PAM CHLORIDE) in Navy and Coast Guard ships and overseas activities. Funds allocated for the initial distribution of these items have been exhausted and the funding and control of this program must now be borne by each activity. A list of additional material required in the treatment of chemical agent casualties may be found in reference (b).

ELIGIBLE MEDICAL INSERVICE RESIDENCY TRAINING PROGRAMS

SPECIALTY TRAINING PROGRAM	NAVAL HOSPITAL								
	Bethesda Maryland	Boston Massachusetts	Camp Pendleton California	Great Lakes Illinois	Jacksonville Florida	Oakland California	Philadelphia Pennsylvania	Portsmouth Virginia	San Diego California
ANESTHESIOLOGY	X	X				X	X	X	X
DERMATOLOGY							X		X
FAMILY (GENERAL) PRACTICE			X		X				
INTERNAL MEDICINE	X	X		X		X	X	X	X
NEUROLOGY	X								
OBSTETRICS & GYNECOLOGY	X	X		X		X	X	X	X
OPHTHALMOLOGY	X					X	X		X
ORTHOPEDICS	X	X				X	X	X	X
OTOLARYNGOLOGY	X					X	X		X
PATHOLOGY	X					X		X	X
PEDIATRICS	X	X				X	X	X	X
PSYCHIATRY	X					X	X		
RADIOLOGY	X					X	X		X
GENERAL SURGERY	X	X		X		X	X	X	X
UROLOGY	X					X	X	X	X

To be prepared properly for defense against biological and chemical warfare attacks, a comprehensive course of instruction on the basic concepts of self-treatment following exposure to BW/CW agents shall be conducted by activities concerned in accordance with reference (c).

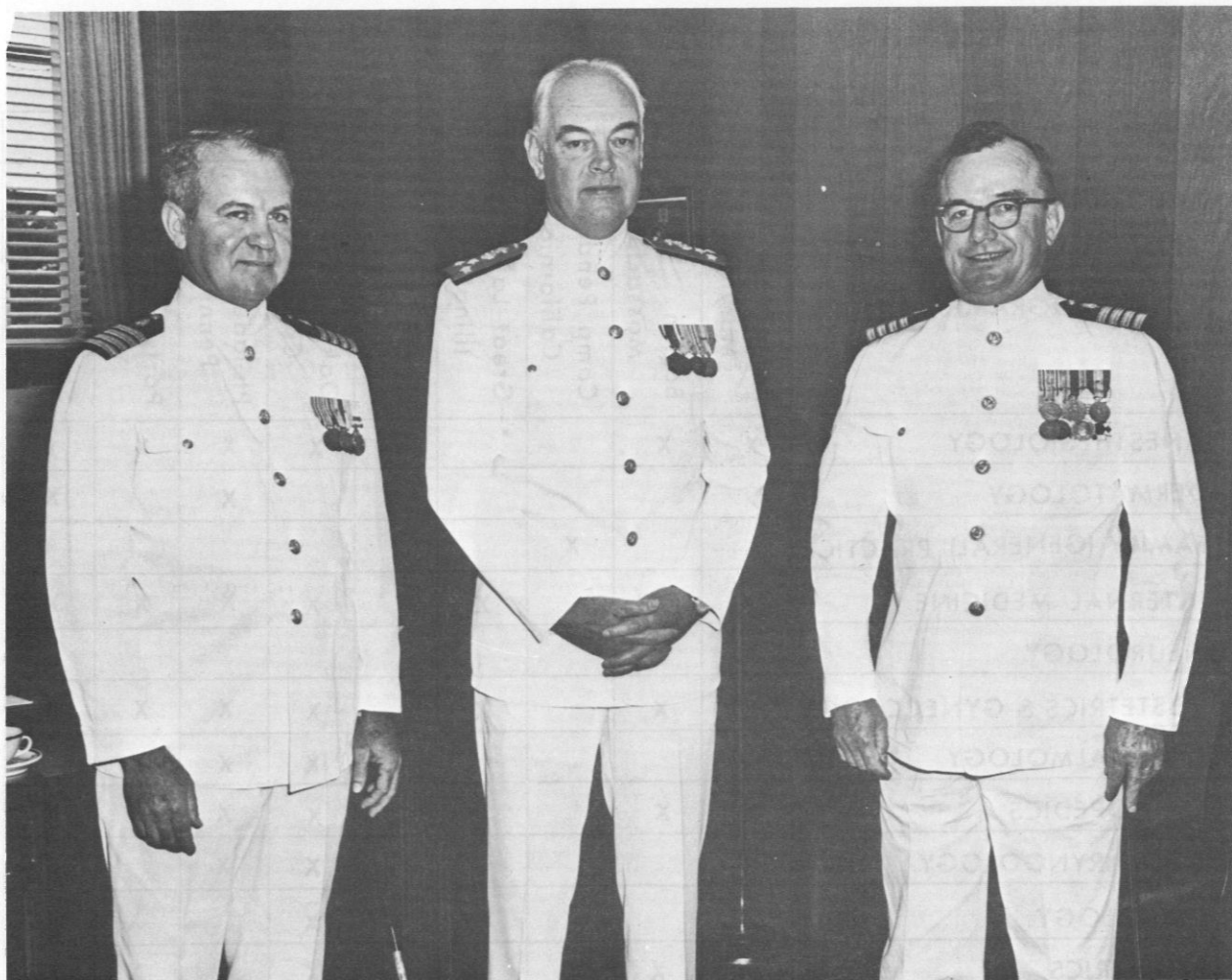
BUMEDINST 1520.16A OF 27 MAY 1971

Subj: Inservice Residency Sabbatical Program

Establishes the subject program (see figure above) which offers outstanding senior residents the opportunity to visit a U.S. medical educational institution under Navy sponsorship. The program will be conducted annually and financial support will be provided by BUMED subject to availability of funds. Eligibility will be limited

to Inservice Residency Training Programs which are three or more years in duration. Residents in two-year inservice programs in which the third year of training is elective will be eligible only during their third year of training. Medical Corps officers in Fellowship Training Programs and those in Outservice Training Programs will not be eligible.

The Chief of Service shall, with the concurrence of his commanding officer, nominate the outstanding senior resident for TAD at an educational institution. The nominating letter shall include all required details and be submitted via the chain of command to reach BUMED (Code 316) by 15 Sept. of each year. Final decisional authority shall rest with Chief, BUMED. ॐ



CAPT Donald J. Doohen, MC, USN, (left) assumed command of the Naval Hospital, Quantico, Va., on 28 May 1971 relieving CAPT George J. Taylor, III, MC, USN, (right) who retired after 28 years service. VADM G. M. Davis, MC, USN, Surgeon General of the Navy and guest speaker, presented CAPT Taylor with a Certificate of Merit. In addition, Dr. Taylor received the Meritorious Service Medal from LGEN William G. Thrash, USMC, Commanding General, Marine Corps Development and Education Command, Quantico. 🇺🇸

SPECIAL SERIES NECs

Special Series NECs (Navy Enlisted Classifications) are those NECs which are not related to any particular general or service rating. They are used to identify billet requirements which are not sufficiently identified by rates, and to identify the personnel who are qualified to be distributed and detailed to fill these requirements. The requirements for qualifications and assignment of these NECs are listed in the Manual of Enlisted Classifications (NAVPERS 15105). 🇺🇸

AWARDS AND HONORS

Navy Cross

Kinnard, Donel C., HMC, USN

Silver Star Medal

Frykman, Darrell P., HM2, USN
Kovach, Gary S., HM3, USN
Luehrs, Richard E., CAPT, MC, USN
Smith, Gerald W., Jr., HM3, USN

Legion of Merit

Jahnke, Leonard P., CAPT, MC, USN
Luehrs, Richard E., CAPT, MC, USN
Sazima, Henry J., CAPT, DC, USN

Navy and Marine Corps Medal

Cronin, Walter G., HM3, USN
McClanahan, Thomas B., HM3, USN
Villa, Victor, HM3, USN

Bronze Star Medal

Barker, Gene A., HMCS, USN
Barnhart, Edward H., HM3, USN
Hewitt, John R., HM1, USN
Hipple, Robert L., HM3, USN
Leadford, William M., LCDR, MSC, USN
Mickey, Larry M., HM3, USN
Mulcahy, John J., HMC, USN
Nolan, Mark W., HM3, USN
Rambur, Michael J., HM3, USN*
Steinke, Dale E., HM2, USN
Stringham, Stanley C., LCDR, MSC, USN
Valdenegro, Frederico T., HM3, USN

Meritorious Service Medal

Allen, Robert V., CDR, MSC, USN
Conaway, Theodore H., Jr., CAPT, MSC, USN
Fabrizio, Francis J., RADM, DC, USNR (Ret.)
Jones, William H., CAPT, MSC, USN
Lawson, William G., CAPT, MC, USN
Miller, Lloyd W., CAPT, MSC, USN
Savarese, Charles J., Jr., CDR, MC, USNR

Air Medal

Orloff, Kenneth M., HM3, USN

Navy Commendation Medal

Bigelow, Randolph W., HM3, USN
Birkeland, William, HM3, USN
Bohner, Joseph J., HM1, USN
Briere, Gerald P., HM1, USN
Brown, John C., HM3, USN

Navy Commendation Medal (Con.)

Bryant, Eugene M., Jr., LCDR, MSC, USN
Bullard, Charles R., HM1, USN
Burnette, Terry D., HM1, USN
Collins, Patrick J., HMC, USN
Combs, Carrol H., HMCS, USN
Demo, James R., LCDR, MSC, USN
Dew, James C., Jr., HN, USN
Dorsey, Tommy J., LT, DC, USNR
Dumlao, Larry V., HMCS, USN
Fishel, Douglas G., HM2, USN
Fisk, Royce S., HM3, USN
Gailey, James A., HM2, USN
Garrett, Thomas M., HMC, USN
George, Maburn R., HM3, USN
Gilbreth, Reginald W., HMCM, USN
Habell, David F., HM3, USN
Haese, John A., HM3, USN
Harvey, James G., HMC, USN
Haviland, George V., HMC, USN
Hench, Douglas G., HM1, USN
Hestad, James F., HMC, USN
Jacobs, John W., HMCS, USN
Jones, Jefferson J., HM1, USN
Korp, Helmut W., HM3, USN
Lindsay, Roger E., HMCM, USN
Lodge, David B., HMC, USN
Mathewson, Gordon W., LT, MSC, USN
McCormick, Richard M., HM3, USN
Miller, Edwin B., CAPT, MSC, USN
Mitton, Clifford G., Jr., HMC, USN
Moore, Walter C., Jr., HM3, USN
Permar, William F., HMC, USN
Phillips, John H., HMCM, USN
Rathbun, Jesse E., HM2, USN
Rhode, William, HMCS, USN
Richardson, James W., CDR, MSC, USN
Sayson, Ernesto M., HMC, USN
Stoltz, John A., HM3, USN
Strange, Earle F., HM1, USN
Wallace, Douglas A., HM2, USN
Wehrbein, Boyd C., HM2, USN
Woods, Rex, HMC, USN

Navy Achievement Medal

Adams, Edwin C., Jr., HMC, USN
Aubrey, James R., HMC, USN
Aymond, Joseph D., Jr., HM2, USN
Backus, Gerald G., HMC, USN
Barry, Michael J., HM1, USN
Bassett, Eugene G., HM2, USN

Navy Achievement Medal (Con.)

Berdine, David C., HM2, USN
Brooks, Robert L., HM1, USN
Coberly, Claude L., HM3, USN
Cole, Jimmy W., HM3, USN
Comley, Raymond, HM2, USN
Cote, Wayne F., HM1, USN
Courville, Jones R., HM3, USN
Cox, Robert L., HMC, USN
Coyle, Charles P., HM1, USN
Crawl, Thomas W., HMC, USN
Cushing, Stephen C., HM2, USN
Davis, Walter R., HM1, USN
Dawkins, William E., HM1, USN
Derby, Michael R., HM2, USN
Dewald, Robert J., HMC, USN
Dionne, Ronald D., HN, USN
Dixon, Gilbert H., HMC, USN
Ebert, Thomas A., HM2, USN
Elvin, Ronald J., HM3, USN
Evans, Arnold D., HM3, USN
Fink, Larry W., HM1, USN
Fitch, David A., HM3, USN
Flower, John F., HM1, USN
Flowers, Richard H., HM3, USN
Frasier, Donald E., HMC, USN
Fulton, James E., HM1, USN
Harley, Lewis K., HM1, USN
Harmon, Marion H., HMCM, USN
Herrick, Richard J., HM3, USN
Higginbotham, Thomas J., HM1, USN
Horvath, John, HM1, USN
Hurd, Michael W., HM2, USN
Hurst, Wesley H., HM3, USN
Johns, Lowell D., HN, USN
Johnson, Donnie L., HMC, USN
Kaiser, Eric P., HMC, USN
Kania, Richard E., HM1, USN
King, James E., HM1, USN
Kintz, Robert L., HM1, USN
Kotschi, Edward G., HMC, USN
Kunkel, Clyde E., HM1, USN
Lantis, Raymond B., HM1, USN
Lanza, Vincent J., HM1, USN
Leonard, Benny R., Jr., HMC, USN
Levin, Michael L., HM3, USN
Lilenthal, Otto H., HM2, USN
Looker, Wesley E., HM3, USN
McCormick, Jimmy R., HMC, USN
McKeen, Clifford H., HM3, USN
Melrose, Paul E., HM1, USN

Navy Achievement Medal (Con.)

Merritt, Stanley C., HM3, USN
Minor, Ira L., HMC, USN
Munday, Joseph T., HM2, USN
Myrah, James L., LCDR, MSC, USN
Neece, Gary L., HM3, USN
O'Connor, William E., HM1, USN
Opdenhoff, David E., HM2, USN
Peck, Marchell, HM1, USN
Peery, James W., HM1, USN
Paternell, Thomas J., HN, USN
Pitts, Charles G., HMC, USN
Rebholz, Gary L., HM2, USN
Reoh, Roucal E., HMC, USN
Rias, Michael D., HM3, USN

*Awarded posthumously


Navy Achievement Medal (Con.)

Rice, Stephen C., HM1, USN
Rogal, Kurt R., HM3, USN
Rollen, James H., HM1, USN
Sallee, James D., HM1, USN
Sallee, John W., Jr., HM1, USN
Schmidt, Anthony A., HM3, USN
Schmillen, Donald G., HM1, USN
Shelton, Donald O., HM1, USN
Shepherd, Warren L., HM1, USN
Sherry, Gregory J., HM3, USN
Siebert, Roger D., HM3, USN
Silk, Garry J., HM2, USN
Solberg, Larry D., HM2, USN
Sullivan, Michael F., HM3, USN

Navy Achievement Medal (Con.)

Sweeney, Garrett A., HN, USN
Tenorio, Pacifico A., HMC, USN
Thompson, James R., HM1, USN
Turney, Curtis N., HM2, USN
Twiner, Jackie S., HM1, USN
Waisanen, Lari A., HM3, USN
Warman, Richard T., HN, USN
Weston, Gary L., HM3, USN
Wiken, Leslie E., HM2, USN
Wimmer, Jeffrey D., HM3, USN
Wiseman, Richard J., HM2, USN

Air Force Commendation Medal

Messer, Eugene J., CDR, DC, USN 

AMERICAN BOARD CERTIFICATIONS

American Board of Anesthesiology

CDR William M. McDermott, Jr., MC, USN

American Board of Endodontics

CDR Malcolm S. Davis, DC, USN

American Board of Family Practice

LCDR Clyde K. Meade, MC, USN

American Board of Internal Medicine

CDR Carl R. Bemiller, MC, USN, in the subspecialty
of Cardiovascular Disease
LCDR Nicholas B. Cirillo, MC, USN
LCDR James C. Dillon, MC, USNR
LCDR David R. Foreman, MC, USN
LCDR Frank M. Griffin, MC, USNR
LCDR Donald J. Kearney, MC, USN
LCDR Charles W. Shaeffer, MC, USN
LCDR John M. Smith, Jr., MC, USNR
LCDR Walter V.R. Vieweg, MC, USN

American Board of Ophthalmology

LCDR George M. Bohigian, MC, USNR
CDR Robert L. Fulwyler, MC, USN

American Board of Oral Pathology

CAPT Seymour Hoffman, DC, USN

American Board of Oral Surgery

CDR Delmar D. Albers, DC, USN
CAPT William R. Hiatt, DC, USN
CDR Walt W. Magnus, DC, USN
CDR Eugene J. Messer, DC, USN

American Board of Oral Surgery (Con.)

CDR Herbert O. Scharpf, DC, USN

American Board of Orthopaedic Surgery

LCDR Tirunilayi A. Balakrishnan, MC, USNR
LCDR William E. Billings, MC, USN
CDR William A. Elliot, MC, USN
LCDR Don L. Fong, MC, USN
LCDR Frank P. Maldonado, MC, USNR
LCDR Joseph A. Matan, MC, USN
CDR Gordon W. Philip, MC, USN

American Board of Otolaryngology

LCDR Jesse A. Marcel, MC, USN

American Board of Pathology

LCDR David F. Garvin, MC, USN

American Board of Pediatrics

LCDR Rel L. Gray, MC, USNR
LCDR Joseph J. Herbert, MC, USNR
LCDR Joseph V. Morrison, Jr., MC, USN
LCDR Brian K. Rizen, MC, USNR
LCDR Robert David Stacks, MC, USNR

American Board of Preventive Medicine

LCDR Charles H. Bercier, Jr., MC, USN
(Aerospace Medicine)
CDR Paul H. Farrier, Jr., MC, USN
(Occupational Medicine)

American Board of Prosthodontics

CDR Robert K. Fenster, DC, USN

American Board of Prosthodontics (Con.)

CDR Don G. Garver, DC, USN

American Board of Psychiatry and Neurology

CDR Evans Diamond, MC, USN (Neurology)

CAPT Orren LeRoyce Royal, MC, USN (Psychiatry)

CDR Henry J.T. Sears, MC, USN (Psychiatry)

American Board of Radiology

LCDR Larry H. Adams, MC, USN

CDR John D. Marriott, MC, USN

LCDR Martin S. Oppenheim, MC, USNR

American Board of Surgery

LCDR Peter B. Blanchard, MC, USN

CDR Robert C. Cochran, MC, USN

LCDR "T" James Guzik, MC, USN

LCDR David M. Knize, MC, USNR

LCDR Paul A. Locascio, MC, USN

LCDR George R. Looney, MC, USN

CAPT Skender Nuredini, MC, USN

LCDR William P. O'Grady, MC, USNR

LCDR James H. Oury, MC, USN

LCDR William C. Stone, MC, USN

LCDR Samuel W. Williams, MC, USN ☸

VERSATILE VEHICLE TESTING FOR ANTARCTIC OPERATIONS

PORT HUENEME, Calif. (NAVNEWS) . . . An experimental 16-wheel, five-ton, low ground pressure (LGP) vehicle designed by the Naval Civil Engineering Laboratory (NCEL) here — primarily for crash-rescue operations in Antarctic regions — is proving to be a versatile transport.

A prototype is undergoing additional field tests, but early results indicate the unique ice-snow vehicle, using high flotation tires, can travel in mud, through swamps, and on sandy beaches. It was designed basically to travel 35 miles an hour over any terrain.

The Laboratory hopes to ship the vehicle to McMurdo Station, Antarctica, this Fall for extensive operational tests. It will be loaded with fire-fighting equipment and placed on standby for crash-rescue missions while maintaining an active schedule of tests.

It is capable of compound and crab steering in close quarters where the vehicle can't go straight ahead or a tight maneuver is required.

The LGP floats, even when fully loaded. Thanks to its 16 tires, each four feet high, the vehicle floats with only half a wheel submerged in water.

This added factor plus the load carrying capacity and maneuverability, has elevated the LGP from the status of a single special-task vehicle to one that could perform a variety of transportation tasks for the Navy in all types of weather and under various conditions. ☸

LET JUNIOR AT THE HELM

"The Junior Officer Award for Excellence in Shiphandling" will go to junior officers who have demonstrated exceptional shiphandling abilities. Z-GRAM 31 announced the competition and encourages commanding officers to let junior officers handle the ship.

The shiphandling award winners will be permitted to name their next normal duty assignment. ☸

MILITARY CLAUSE

Being in service does not authorize you to move and break your lease ad lib. Before signing your lease, insert that military clause. ☸

ANIMAL CARE FACILITY ACCREDITED

The Animal Care Facility at the Naval Submarine Medical Research Laboratory, Naval Submarine Medical Center, at the Groton Submarine Base, Conn., received its accreditation on 4 June 1971 from the American Association for Accreditation of Laboratory Animal Care, Joliet, Ill.

The Naval Submarine Medical Research Laboratory thus became the fourth naval medical research activity to have an accredited animal care facility, the other three being the Naval Aerospace Medical Center, Pensacola, Fla.; Naval Medical Research Unit No. 1, Oakland, Calif.; and Naval Medical Research Unit No. 4, Great Lakes, Ill.

Whenever research projects at the Naval Submarine Medical Research Laboratory require the use of animal subjects, these investigations are carried out in facilities meeting the rigid standards of the American Association for Accreditation of Laboratory Animals.—PAO, Naval Submarine Medical Center, Naval Submarine Base, New London Groton, Conn. 🍀

UPCOMING MEETINGS

Association of American Medical Colleges, Annual Meeting, Oct. 28 - Nov. 1, 1971, Washington Hilton Hotel, Washington, D.C. "Interrelationships of Government and the Academic Medical Centers in Meeting Society's Needs for Health Care."

The Tenth Annual Conference on Research in Medical Education, in conjunction with the above meeting, Oct. 31 and Nov. 1, 1971, Washington, D.C.

International Symposium on "Automatic Control and Computers in the Medical Field," Sept. 27 to Oct. 1, 1971, at the Palais des Congrès in Brussels, organized by the Institut Belge de Régulation et d'Automatisme. 🍀

✠ In Memoriam ✠

CAPT John W. Flynn, MC, USN, died on 21 June 1971 at Bethesda Naval Hospital, NNMC, after a brief illness. Born 6 July 1923 and a native of Baltimore, Md., CAPT Flynn received his M.D. degree from Georgetown University Medical School and was commissioned ensign on 23 June 1943. His naval career began in Sept. 1943 at the Naval Hospital, Bethesda, Md., where he also served three subsequent tours

during his 28½ years of active duty. CAPT Flynn was awarded the Navy Commendation Medal for outstanding service as a battalion surgeon with the 1st Marine Division during the Korean conflict. From June 1956 to Aug. 1958, CAPT Flynn served as a member of the Physical Review Council, BUMED. After completing a course of instruction at the Armed Forces Staff College, Norfolk, Va., in Jan. 1962, he served briefly as Director, Outpatient Services, Naval Hospital, Portsmouth, Va. In March 1962 CAPT Flynn assumed duties as Head, Active Duty and Disposition Branch, PQ&MR Division, BUMED, in which capacity he served until his death. CAPT Flynn is survived by his wife, Elizabeth, and four children, Elizabeth Anne, John Joseph, Mary Bridget and Ann Kathleen; his mother, and a brother.

CAPT William W. Henderson, MC, USN (Ret.) died on 8 June 1971 due to injuries received in an automobile accident. He was born in Chico, Tex., on 30 Oct. 1912. CAPT Henderson received a B.S. degree from the University of Houston and his M.D. degree from Baylor University College of Medicine. On 12 Mar. 1942, CAPT Henderson was appointed Assistant Surgeon, LT(jg), USNR, and reported for active duty on 5 Apr. 1942. In Sept. 1942 he received his appointment to USN. During his naval career, CAPT Henderson served aboard several naval air stations in the U.S. He also served aboard the USS Bon Homme Richard (CVA-31) and USS Boxer (LPH-4). On 1 Dec. 1963 CAPT Henderson's name was placed on the Retired List. He is survived by his wife, Jane, and a son, William Henderson, Jr.

CAPT Ernest H. Joy, MC, USN (Ret.) died of cardiac arrest on 4 July 1971 at the Naval Amphibious Base, Little Creek, Va. He was born on 24 Sept. 1903 in Bar Harbor, Me. CAPT Joy graduated from Tufts Medical School. In 1936 and 1937, he served as a member of the Governor's Staff, State of N.H. He was commissioned LT(jg), MC, USNR in Nov. 1938 and prior to being called to active duty in Feb. 1941, Dr. Joy was engaged in civilian practice. He served as Senior Medical Officer at several naval medical facilities and twice served in that capacity in the USS Yosemite with additional duty on DESLANT Staff. In 1954 he attended a course of instruction at the Special Weapons School, Norfolk, Va. CAPT Joy's name was placed on the Retired List in July 1965. At the time of his death he was director of the Health Department of the city of Chesapeake, Va. He is survived by his wife, Leona, a sister, four daughters and two sons. A son, LT Ernest H. Joy, USN, is presently serving aboard the USS Johnson (DD-821). 🍀

United States Navy Medicine

CORRESPONDENCE AND CONTRIBUTIONS from the field are welcomed and will be published as space permits, subject to editing and possible abridgment. All material should be submitted to the Editor, U.S. Navy Medicine, Code 18, Bureau of Medicine and Surgery, Washington, D.C. 20390

NOTICES should be received not later than the third day of the month preceding the month of publication.

PROFESSIONAL PAPERS AND ARTICLES should be typewritten on one side of the paper, double spaced, with liberal margins. Original and one carbon copy are required. Generic names of drugs are preferred. If the author's present affiliation differs from that under which the reported work was done, both should be given. Unless otherwise indicated, it will be assumed that the article presented has not been previously printed or delivered elsewhere. Papers which have been delivered or printed elsewhere, covered by copyright, cannot be reprinted in Navy Medicine without the written permission of the author(s) and copyright holder. It is the responsibility of the author(s) to inform U.S. Navy Medicine when the material submitted has been previously used or copyrighted. Navy Medicine will be happy to request permission to reprint from the copyright holder when this is necessary.

ILLUSTRATIONS are acceptable when they substantially contribute to the understanding of the basic material. Only distinct, glossy, black and white **PHOTOGRAPHS** which are functional can be printed. Prints should not be mounted, stapled, clipped or otherwise deformed and can be marked lightly on the back with the figure number. Legends should be typed consecutively on a separate paper with the indicated figures; credits for the photography may also be included. Identities of patients should be masked. **DRAWINGS, TABLES AND GRAPHS** should be minimal in number and properly labeled. They should be neatly done in heavy black ink on white paper, one to a page.

SUGGESTIONS are invited concerning U.S. Navy Medicine, its content and form.

U.S. NAVAL PUBLICATIONS and FORMS CENTER
ATTN: CODE 306
5801 Tabor Avenue
Philadelphia, Pa. 19120
Official Business

POSTAGE AND FEES PAID
NAVY DEPARTMENT



U.S. NAVY MEDICINE